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
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2. Becoming a supervisor

2.1 Supervisor qualifications and experience

Doctors in training are required to have a 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 experience
- (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 are required to:

- understand the training requirements and the breadth and scope of knowledge, skills and experience that are required to gain FACRRM
- understand the type of supervision that is required for an individual doctor in training
- negotiate methods and frequency of communication with the doctor in training
- meet with the doctor early in the placement to discuss and appraise the doctor's skills and experience and develop a learning plan
- provide appraisal and formative assessment of the doctor in training in accordance with their stage of learning
- provide or facilitate structured educational activity requirements according to the doctor in training's stage of training and experience
- organise 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
- participate in supervisor training and other activities to further develop supervision, teaching and mentoring skills

It is preferred that ACRRM supervisors hold FACRRM. If you do not hold FACRRM, you may wish to consider 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
- improves the quality of your own practice
- helps you to learn how to learn
- increases your knowledge and helps to identify gaps in your knowledge
- keeps you up to date
- gives an opportunity to give back to the profession
- improves the quality of the workplace, through sharing knowledge and skills and increased teamwork
- expands contacts and networks
- reduces isolation
- gives you diversity in work and
- allows you to find out about other professional opportunities.

Supervisors' roles may be remunerated; details on the level and type of remuneration are provided by the training organisation that engages you as a supervisor.

Supervisors may claim professional development recognition for providing supervision and gaining accreditation as a training post. Undertaking education activities such as the ACRRM Orientation to Fellowship Training online module are recognised. 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.

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 be provided off-site where the training post has no on-site supervisor or the onsite supervisor does not have adequate rural or remote experience.

The Standards for Supervisors and Training Posts for the relevant stage of training detail the process to become accredited as a supervisor.

2.5 Reducing risk as a supervisor

Supervisors are recommended to advise their medical defence organisation of their intent to provide supervision and check with them that 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.

2.6 How to get your facility ready to train

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 registrar and information detailing how the post organises orientation to the post, teaching, learning and supervision.

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.

Teaching plans provide a description of:

- the post, the patient or practice population
- clinical, educational and social strengths and opportunities to offer registrars
- how the post provides opportunities for registrars to be involved in quality assurance, clinical audits and peer review
- how the post provides opportunities for off-site visits relevant to rural and remote medicine, and
- clinical and teaching resources available.

Teaching plans provide information on:

- the orientation program
- a timetable of education activities and identifies who is responsible
- supervision arrangements including arranging a backup supervisor when principal supervisor not available, and
- formative assessment.

Teaching plans provide information for registrars on operational arrangements including:

- staffing
- rosters, and
- extended care responsibilities such as hospital work, after hours, home visits and nursing home visits.

3. Supervisor training and support

3.1 Australian College of Rural and Remote Medicine

Staff

ACRRM's Education Services team are available to provide advice and guidance on supervision, training and assessment requirements for ACRRM doctors in training. Phone (07) 3105 8200 or toll free 1800 223 226 or email:
training@acrrm.org.au for training related questions,
assessment@acrrm.org.au for assessment related questions and
postaccreditation@acrrm.org.au for training post accreditation questions.

Online learning

ACRRM online educational resources are available 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. These are accessible from the ACRRM website. They include

- ACRRM orientation to Fellowship
- ACRRM cultural Safety
- Foundations of Rural Generalist Supervision: Introduction
- Foundations of Rural Generalist Supervision: Supervision Placement
- Foundations of Rural Generalist Supervision: Supervision and Teaching
- Foundations of Rural Generalist Supervision: Consultation and Observation and Feedback

These online course provide an overview of the essential skills for supervisors and online instructional courses on ACRRM assessment modalities including StAMPS, MCQ Case Based Discussion and MiniCEX.

Some of the frequently accessed resources include:

- Rural Clinical Guidelines (downloadable to mobile phones)
- Connect@ACRRM (discussion forum for peer networking)
- TeleDerm (case discussions and case library of over 3000 cases)
- Rural EM Forum
- 150 Shades of Radiology
- Ophthal Assist
- Telehealth Provider directory.

Workshops

Many workshops and presentations at 'Rural Medicine Australia' (RMA), the annual conference for ACRRM and Rural Doctors Association of Australia contain content 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.

3.2 Training Organisations

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 providing orientation, training and support for supervisors.

The hospitals and health services will also have a role in supporting registrar training and supervision, as will the Rural Generalist Coordinating Units in each jurisdiction. In some situations, employer organisations such as the Australian Defence Forces or the RFDS may also play an important role.

For registrars on the Independent Pathway registrar training and supervisor support is provided by the ACRRM training team.

3.3 General Practice Supervisor Association

The 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 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 (NT&C) between supervisors and doctors in training on behalf of supervisors.

GPSA has a wide range of resources publicly available including a series of teaching plans. These may be downloaded from the GPSA website.

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 also 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, 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

Core Generalist Training (CGT) covers three years of training

- 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.

Advanced Specialised Training

Advanced Specialised Training (AST) covers one year of training

- 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 program summary

The table 1 below provides a summary of the training program requirements.

Rural Generalist Training Program		
Duration	Minimum 4 years	
Requirements	**Core Generalist Training (CGT)**	**Advanced Specialised Training (AST)**
Time	Minimum 3 years	Minimum 1 year
Training	Commence at PGY 2 or above.	Commence at PGY 3 or

	Train in regional, rural and remote general practices, hospitals, Aboriginal and Torres Strait Islander health services and retrieval services. Complete minimum full time equivalent training in the following: • primary care - six months • secondary inpatient care - three months • emergency care - three months • rural or remote practice -12 months • paediatrics - 10 weeks • obstetrics - 10 weeks • anaesthetics - 10 weeks	above. Train in regional, rural, remote, or city health services as appropriate to the chosen discipline. Complete training in at least one of the AST disciplines: • Aboriginal and Torres Strait Islander Health • Academic Practice • Adult Internal Medicine • Anaesthetics • Emergency Medicine • Mental Health • Obstetrics and Gynaecology • Paediatrics • Palliative Care • Population Health • Remote Medicine, and • Surgery.
Education	Successfully complete: • the education program as outlined and delivered by the College or training organisation • Rural Emergency Skills Training (REST) and another EM course/s • a minimum of four "FACRRM recommended" online learning courses	Successfully complete: • the education provided by the training post and • specific courses as outlined for each of the AST
Assessment	Successfully complete: • Six monthly supervisor reports • Nine formative mini Clinical Evaluation Exercises (miniCEXs) • Multi-Source Feedback (MSF) • Multiple Choice Question (MCQ) assessment	Successfully complete: • Six monthly supervisor reports • Work based and external assessments as specified for each AST

	• Cased Based Discussion (CBD) • Structured Assessment using Multiple Patient Scenarios (StAMPS) • Procedural Skill Logbook (logbook)	See Fellowship Training Handbook.

Detailed information on training requirements may be found in the Fellowship Training Handbook.

4.3 Rural Generalist Curriculum

The ACRRM Rural Generalist Curriculum is on the College website.

The Rural Generalist Curriculum provides a definition of Rural Generalist Medicine and describes the competencies, knowledge, skills and attributes required to be a Rural Generalist.

The curriculum informs the training, education and assessment requirements to achieve Fellowship. Therefore, an understanding of the curriculum is essential for all registrars.

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 and choose one specialised area in which they demonstrate meeting the competencies at the Advanced Specialised standard.

These standards are described in the curriculum. The Curriculum also details the knowledge, skills and attributes in 37 clinical and non-clinical Learning Areas. The Learning Areas all include Core Generalist content and Advanced Specialised content is 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 and then update 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. Ask the doctor to share their training plan with you.

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 also identify any gaps the registrar may have at training commencement, for example experience in Obstetrics and Gynaecology, Anaesthetics or Paediatrics. Doctors may fill these gaps through undertake 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 assessable learning outcomes are defined in the ACRRM Rural Generalist Curriculum and the assessment blueprint details which of the assessment modalities examines each of the learning outcomes. This can be found in the Fellowship Assessment Handbook.

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 described in the curriculum and reinforcing and enhancing this by using the teaching activities outlined later in this resource.

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

Type of assessment	**Who conducts the assessment**	**How to support the doctors in training**	**Resources**
miniCEX	Supervisors and MEs	Use miniCEX forms each time you observe and provide feedback to a doctor in training	MiniCEX training course for clinicians (Online course) MiniCEX forms
Physical	Supervisors	Include observation of	Formative miniCEX

examination	and MEs as part of miniCEX	physical examination in observed consults	Physical Exam Reference
Procedural skill logbook	Skills are certified by a doctor at the rank of at least Senior Registrar	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	Rural Generalist Curriculum
Multi Source Feedback (MSF)	Range of colleagues and patients	Encourage to undertake early in training when established in a general practice. Discuss MSF report once completed. Note there should be no surprises in the feedback provided by supervisors in MSF, as it should have been previously.	How to guide for reading ACRRM MSF reports
Multi Choice Questions	ACRRM	Facilitate broad range of experience. Discuss assessment readiness with the doctor in training. Encourage early and structured preparation for the assessment.	Introduction to MCQ (online course)
Case Based Discussion	ACRRM	Conduct regular case based discussions with the doctor. Use the ACRRM forms to structure and document feedback. Discuss assessment readiness with doctor in training. CBD must be undertaken in a post that provides continuity of care. Assist with choosing suitable cases for summative	Introduction to CBD Assessment (online course)

		assessment. Provide a venue and invigilator for CBD; note CBD can be conducted in the training facility.	
StAMPS	ACRRM	Facilitate a broad range of experience. Discuss assessment readiness with the doctor in training. StAMPS should be the last assessment undertaken, after successfully completing the rest of assessments. 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.	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 and the implications they have for teaching and learning described.

5.1.1 Principles of adult learning

Adult learners generally:

- find learning rewarding
- use all their senses to learn
- learn more effectively when they can relate new information to their existing knowledge
- need opportunities to practise their new skills and apply their new knowledge
- remember best the first and last things in a learning session
- need feedback on their progress
- need to be actively involved in the learning process
- 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:

- *Visual/Spatial Intelligence*: These learners tend to think in pictures and need to create vivid mental images to retain information. They enjoy looking at maps, charts, pictures, videos, and movies.

- *Verbal/Linguistic Intelligence:* These learners have highly developed auditory skills and are generally eloquent speakers. They think in words rather than pictures. They prefer using words, both in speech and writing.

- *Logical/Mathematical Intelligence:* These learners think conceptually in logical and numerical patterns making connections between pieces of information. Always curious about the world around them, these learners ask lots of questions and like to do experiments.

- *Bodily/Kinaesthetic Intelligence:* These learners express themselves through movement. They have a good sense of balance and eye-hand co-ordination. Through interacting with the space around them, they can remember and process information. They prefer using their body, hands and sense of touch.

- *Musical/Rhythmic Intelligence:* These musically inclined learners think in sounds, rhythms and patterns. Many of these learners are extremely sensitive to environmental sounds (e.g. crickets, bells, dripping taps). They prefer using sound and music.

- *Interpersonal Intelligence:* These learners try to see things from other people's point of view in order to understand how they think and feel. They are great

organizers. Generally, they try to maintain peace in group settings and encourage co-operation. They use both verbal and non-verbal language to open communication channels with others. They prefer to learn in groups or with other people.

- *Intrapersonal Intelligence:* These learners try to understand their feelings, relationships with others, and strengths and weaknesses. They prefer to work alone and use self-study.

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	**Generation X 1963-1981**	**Generation Y 1982-2000**
Description	Work hard out of loyalty, expect long term job, pay dues, self-sacrifice is a virtue, respect authority	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 many jobs, question authority.	Net generation, emotionally uninhibited, several careers over life, limitless choice, option a fundamental right.
Influences	Evidential Experts	Pragmatic practitioners	Experiential peers
Teaching focus	Technical data, evidence	Practical case studies	Emotional, participative
Learning format	Formal structured	Relaxed interactive	Spontaneous multisensory
Learning environment	Classroom style, quiet	Round table, relaxed	Café, music, multimodal
Iconic technology	TV, audio, cassette	VCR, walkman, PC	Internet, email, SMS
Leaders	Command, control	Co-ordination, co-operation	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 & 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 & occasional failure, can use 'self' in consultations, arranges own educational program

- "Autonomy" includes negotiates transition from doctor in training to independent doctor, finds & 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 for example, 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 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 required to have 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:

Beginning

- Engagement
- First impressions
- Presenting symptoms
- Why the patient had come to see the doctor at this time

Middle

- Context of the consultation, relevant issues
- Systems review, what was required?
- Patient's perspective (their feeling, ideas, fears & expectations)

End

- General Issues
- Time management
- Preventative issues
- Evidence based medicine

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. 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.

The 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 and display attitudes and values
- Able to give feedback that provides the doctor in training with insight about what they actually do and information about the possible consequences of their actions
- Facilitates completion of the end of term assessment form on the doctor in training

The barriers to direct observation:

- Lack of time
- The patients always try and engage the supervisor rather that the doctor in training and this can undermine 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, not an activity additional to in-practice teaching sessions.

- *Set the scene with the doctor in training* - It is helpful to discuss your plans for direct observation with the doctor in training, discuss how these sessions will be conducted and clarify the 'ground rules' for the session. This is especially important for doctors in training who may not have been observed before. These sessions are intended to be formative (provide the doctor in training with information, examples and strategies for improving their clinical and consulting skills). However, if a supervisor identifies problems or has significant concerns about the doctor in training's performance then this should be discussed with their medical educator so that an appropriate plan can be implemented.

- *Observing* - It is probably best that the observer's chair is out of the line of sight of the patient and the doctor in training so that the focus is on the learner not the patient. Avoiding eye contact with the patient helps them to remain engaged with the doctor in training. This is especially so when the supervisor is observing, and the patient is known to the observing doctor. It is also useful to adopt the principle that you will not interrupt unless directly asked by the doctor in training or if you feel that they are about to do something that is unsafe. It is useful to discuss with the doctor in training what your action will be in this situation (e.g. send the patient to collect a urine sample (if appropriate), 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) - This is the most important aspect of a direct observation session and when successful will enable the doctor in training to improve in their future performance.

- *Develop some skills in questioning* - Good questioning is the key to good teaching and questions that raise the doctor in training's awareness of the clinical process are often the most useful (e.g. "what do you think is going on here?" "What led you to that diagnosis?")

- *Learning the skills* - There are several opinions as to whether feedback ensuing from direct observation should concentrate on content or process issues in the consultation - both content and process are important. 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.

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, but 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.

- Information transfer, explanations, patient understanding
- Adherence
- Being rational, investigations, prescribing, use of specialists & community resources
- Safety-netting
- Follow-up

5.2.4 Topic tutorials

These can be directed by the learner, or by other opportunities that present themselves during the term. It is appropriate to ask the learner to prepare material for teaching, for example to review the evidence around a topic, and for the supervisor to overlay that evidence with experience in the rural and remote context. It is also helpful for the doctor in training to be involved in teaching others, for example more junior doctors. There are often opportunities through teaching sessions or upskilling with other staff in which the doctor in training can participate.

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

5.2.5 Referral letter review

This is a useful exercise for a teaching session and can achieve the following aims:

- Provide feedback to the doctor in training about the content and quality of their referral letters
- Stimulate discussion about when to use a specialist and specialist services available in the area
- Reviewing the usefulness of the opinion from the specialist
- Introducing the concept of the general practitioner as a coordinator of health care for the patient and patient advocacy
- During this session a copy of the referral letter and the specialist reply are reviewed together. The supervisor should also bring some of their referral letters to the session.

Issues that could be raised include:

- Was the referral necessary? Could the patient have been managed by the general practitioner? If so what knowledge and skills would be needed?
- Were the specialist's findings and conclusions like the doctor in training's? If not what was different and what does the doctor in training think about this? Have they learnt anything?
- Were there any investigations arranged by the specialist about which the doctor in training needs more knowledge?

- Is there a need for the doctor in training to gain more knowledge about the treatment recommended by the specialist?
- Was the specialist's opinion helpful in the ongoing management of the patient?
- 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 concepts and processes involved in performing clinical audits in training. The doctor in training may be required to complete a clinical audit in training project as part of their training requirements, devoting a teaching session to discussing this would be very useful for the doctor in training.

This session could also introduce the doctor in training to organisations such as the National Prescribing Service, through discussion of the various NPS audits in training activities. In addition, it can increase the doctor in training's awareness of the QA and CPD program activities and the role of clinical audits in training.

5.2.7 Practical procedure teaching sessions

It is always useful to determine if a doctor in training has procedural skills in which they have not yet had experience. These procedures need to be identified in advance, otherwise learning and teaching opportunities may be missed. 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.

These include:

- Knowledge
  - knowledge required in order to successfully perform the procedure
  - relevant anatomy
  - indications and contraindications to local anaesthetic use
  - complications etc.
- Skills
  - skills required to successfully perform the procedure (e.g. preparation, actual technique, manual dexterity)
- Communication
  - information that needs to be communicated to the patient (e.g. consent, patient comfort)
- Attitudes
  - is the doctor in training aware of their limitations and when to get help?

A useful approach when learning procedural skills:

- Discuss the important aspects of performing the procedure with the doctor in training, if possible, demonstrate using models.
- 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?
- Observe the doctor performing the procedure and provide feedback.
- 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 students 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:

- 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.

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

- Be constructive:
  - Help provide solutions for areas of weakness.
  - Give positive critique, which looks at "what can be improved" rather than "what is wrong", encourages the doctor in training to look for solutions.

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

- Involve attentive listening.

- 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. . .").

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

- 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.

- 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.

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

- 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.

- Use higher order questions: how, why, tell me about, tell me how. They are good to develop thinking and reasoning skills.
- Restrict the use of lower order questions such as what, when, to when you need to obtain detail.
- Wait and allow for response (up to five seconds) don't speak too soon.
- Follow a poor answer with another question which returns to the issue.
- Resist the temptation to answer learners' questions—use counter questions instead.
- Use statements—for example: “Doctors in training sometimes find this difficult to understand” instead of “Do you understand?” which may be intimidating.
- Sequence questions to draw out contributions or to promote thinking at higher cognitive levels and to develop new understanding, for example given your conclusions about the management of this case how this influence future management in similar situations.

5.3.3 Effective explanations

Providing effective explanations is another important skill:

- Check understanding before you start, as you proceed, and at the end—non-verbal cues may tell you all you need to know about someone's grasp of the topic.
- Give information in “bite size” chunks.
- Put things in a broader context when appropriate.
- Summarise periodically (“so far, we've covered . . .”) and at the end; asking learners to summarise is a powerful way of checking their understanding.
- Reiterate the take home messages.
- Ask the doctor in training to give you feedback on what has been learnt.

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.

- Get a commitment: A question such as “What do you think is happening here?” or “What would be your treatment plan?” helps the learner commit to a diagnosis or treatment option, rather than simply going along with the supervisor’s plans.
- Avoid prompting or suggesting a diagnosis or treatment plan at this point
- Probe for supporting evidence: Explore the doctors thought processes. Was this a lucky guess or a well thought out evaluation?
- Questions such as “Were there any other alternatives you considered?” or “What made you rule out condition X?” are helpful.
- Questions that rely on rote memory, such as “What is the differential diagnosis for retrosternal chest pain?” don’t aid clinical reasoning.
- Teach general rules: Try to find a teaching point that can be applied to other situations.
- Reinforce what was done right: Positive feedback will encourage desirable behaviours.
- Correct mistakes: Point out any errors.

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, but if addressed in a timely and appropriate manner can have a significant impact on their satisfaction with career and life.

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.

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.

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

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. However, as a supervisor, you are likely to come across doctors in training with difficulties of a transient, more personal nature, who for a time need support. 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 seen as a diagnostic process, involving 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, and 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

- 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 (e.g. observations, assessments, appraisals, and reported concerns from others in the team)?
- Recognising signs and symptoms

6.2 Identifying the doctor in training in difficulty

Paice (2006) identifies seven key early warning signs of a doctor in training 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.

Seven key early warning signs:

1. The 'disappearing act': (e.g. lateness; frequent sick leave)
2. Low work rate: (e.g. slowness in doing procedures, making decisions; arriving early, leaving late and still not achieving a reasonable workload)
3. 'Rage': (e.g. bursts of temper; shouting matches; real or imagined slights)
4. Rigidity: (e.g. poor tolerance of ambiguity; inability to compromise; difficulty prioritising)
5. 'Bypass syndrome': (e.g. colleagues, nursing staff and admin staff find ways to avoid seeking the doctor's opinion or help)
6. Career problems: (e.g. difficulty with exams; uncertainty about career choice; disillusionment with medicine)
7. Insight failure: (e.g. rejection of constructive criticism; defensiveness; counter-challenge)

If you notice any of these warning signs in your doctor in training, the first step is to identify an opportunity to share your concerns with the doctor in training, being careful to focus 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.

6.3 Approaching the problem

Is there a problem?

The problem may not lie with the doctor in training but with other medical staff, nurses or other people. Frequently a single event brings the problem to light. You need to gather evidence by your observations or by asking other staff and patients. You can consider obtaining previous term reports and talking to previous supervisors. Then look at the evidence. Is this really a problem or does it represent a personality difference between the doctor in training and me?

What is the problem?

This is what is observed. From these observations 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. Consider the cause(s) using the categories: the doctor in training, the system, and the supervisor. Commonly the cause is a combination of these.

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?

- We don't have the time
- We fear reprisals (even losing our job, getting a bad reference)
- We don't like upsetting people
- We think it may make 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 skills

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.

Address the issue with the doctor

- Do this soon after a problem has been identified.
- Start with 'the quiet chat'.
- Obtain their version of any incidents and observations.
- Obtain their version of their performance.
- Try to reach a consensus on problem and cause.
- Negotiate a plan; this depends on the problem and the underlying cause.
- Develop specific criteria for improvement.
- Make a timetable for monitoring and frequent appraisal.
- Consider referral depending on problem or cause.

Documentation and referral

It is essential that supervisors maintain the doctor in training's rights and privacy and ensure a just process in management. All supervisors should have access to a clearly outlined process to follow for referral that is confidential and independent of career pathways. A person of 'first contact' should be readily accessible and identifiable.

Confidentiality is important. Significant issues should be brought to the attention of the appropriate group and fully documented. For other issues, which are likely to resolve, personal documentation, which can be used if necessary, at a later date, may be wise.

6.5 Prevention

Consider the categories of causes of problems that you can change (i.e. the supervision and the system). A good supervisor, a good training program and supportive administration are essential in preventing the doctor in training from being in difficulty or performing poorly. If problems arise, early identification and early 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 your 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

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

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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