SA IMET SUPERVISION SURVEY 2011
FINAL REPORT

MARCH 2013

Teaching, supervising and mentoring doctors and medical students is important for their development and for the care of patients. It is part of good medical practice to contribute to these activities and provide support, assessment, feedback and supervision for colleagues, doctors in training and students.

AMA Good Medical Practice: A Code of Conduct
for Doctors in Australia (2009)

Executive Summary

Clinical supervision plays a critical role in both the patient care that junior doctors deliver, and the training they receive. This research sought to gather information about how clinical supervision is delivered and experienced in South Australia; views were elicited via online surveys from doctors across the spectrum of training and seniority, who were employed in a variety of healthcare settings.

Over four hundred doctors (representing approximately 8% of the state's medical officer workforce) shared their perspectives; doctors in training described the supervision that they received, as well as that which they provided to medical students and doctors more junior to themselves, and consultants described the supervision they provided for the clinicians in training and students under their oversight. The central themes from the survey responses are shown in Figure 1.

Safety was the foremost driver of clinical supervision at all levels of seniority and training; dedication to this Hippocratic tenet was evidenced throughout respondents' reported actions, beliefs and concerns. In concert with the central theme of patient safety was safety for trainees, the latter upheld through a combination of the treatment trainees provided being appropriate for the patients' needs and appropriate to trainees' level of ability (i.e., safe for the recipient), facilitation of a safe environment for skill development, drawn together into role identity as safe practitioners. Factors supporting patient and trainee safety included support and pastoral care for trainees

Constructive, on-the-job feedback was highly valued by trainees; supervisors who had the ability and inclination to deliver constructive feedback appropriately and supportively were associated with important positive impacts on supervision. Providing anonymous feedback to supervisors did not rank highly as a positive impact, although numerous consultants indicated they would like feedback on their supervision techniques, and that other senior staff could also benefit from this. Providing junior staff with training and monitoring throughout a rotation was valued more highly by trainees than knowledge of assessment tools. Trainees objected to their assessments being conducted by clinicians who had had little opportunity to observe their skill level, and also when the assessor failed to gather information from other sources such as clinicians who were familiar with the trainee. These kinds of practices were said to result in some hardworking doctors being under-evaluated, as well as poorly performing trainees "slipping through the cracks". Conversely, some trainees felt uncomfortable asking questions of or admitting problems to supervisors who were also their assessors, for fear of these events being recorded as weaknesses on subsequent appraisals.

Supervisors being committed to teaching, and having teaching skills were regarded as particularly important positive impacts on supervision. In addition to good clinical skills and seniority relative to the trainee, other characteristics of good supervisors included willingness and enthusiasm for the role, approachability, supportiveness and good interpersonal and communication skills. Many respondents also expressed a preference for supervisors to have undertaken or be willing to undertake relevant training. Although dedication to clinical education was seen as a protective factor given the

challenges posed by conflicting organisational priorities, even passionate teachers could be curtailed through organisational pressure to prioritise clinical duties. The characteristics of trainees influenced supervision to a seemingly lesser extent; supervisors occasionally expressed a preference for supervising juniors with good interpersonal skills and a keen interest in the supervisor's area of medicine. The importance of a good relationship between supervisor and trainee was more important from the trainee perspective than that of the supervisor.

While clinical skills acquisition was understandably the focus of supervision, many respondents noted that developing the skills associated with professionalism (such as communication and interpersonal skills, and how to manage and prioritise workloads) was also very important. Given the existing time pressures, however, these areas tended to be neglected in favour of teaching techniques and procedures.

Pressures imposed by healthcare facilities included time constraints; this was the most commonly cited threat to clinical training. Finding time to supervise as well as meet the service requirements of employing institutions was a struggle faced by a very large number of supervisors. Strong positive impacts for supervision were associated with organisations that valued and supported training. Strategies such as specific rostering, extra remuneration for training, clear contracted requirements and organisational enforcement of supervisory responsibilities were offered as means by which to address unequal supervisory workloads that could result from some senior staff avoiding supervision. Contrasting to this were descriptions of "healthcare factories" who emphasised service delivery to the effective exclusion of clinical training.

Almost without exception, survey respondents felt it was important to receive training in clinical supervision techniques. Workshops were the most popular format for this training, but a range of options were endorsed. Many consultants and smaller proportions of trainees indicated they had undertaken some training in this area. Teaching On The Run was the most commonly cited prior training, although many consultants had undertaken training in supervision and clinical teaching that had been provided through their respective specialty colleges.

This research will be used to guide the next steps of a range of initiatives wherein the South Australian Institute of Medical Education and Training (SA IMET, now known as the SA Medical Education and Training Unit) will work with partners to support clinical supervision in South Australia. These results provide an informed context for the development and delivery of training programs aimed at developing skills in clinical teaching and supervision (for example, providing constructive feedback, or addressing underperformance in trainees), with variations to suit the needs of junior doctors at each level of training, as well as for senior clinicians. The training would likely be best delivered by a clinician in the form of succinct workshops.

The findings also support the development and delivery of training (possibly outside the clinical setting) for non-clinical yet nonetheless important skills (such as managing workflows and prioritisation), which can be refined in the workplace through role modelling.

The insights shared by the respondents in the present research will guide the development of a "toolkit" of training modules designed to facilitate growth of supervisor skills and foster cultural shift toward valuing clinical supervision.

Figure 1 Themes identified from survey findings.

Contents

Introduction

Supervision for junior doctors undertaking postgraduate training was investigated in a study conducted by the South Australian Institute of Medical Education and Training (SA IMET) in 2011. Three online surveys elicited the views of medical students, prevocational and vocational trainees, and senior medical staff, and gathered information on the supervisory practices that are employed in a variety of clinical settings and how effective these practices are.

Selected findings are presented in this summary report. Additional information including the survey items presented with descriptive statistics (measures of central tendency and data distribution) and further aggregated results can be provided on request. In order to preserve respondent confidentiality, data grouped by individual healthcare facilities cannot be supplied.

Method

The surveys asked for demographic details and information about the settings in which respondents were employed. The participants were asked to provide their thoughts on clinically based supervision, including their views regarding its purposes and effects. The trainee medical officers and students were asked about their experiences being supervised, while the senior medical officers, and those trainees who reported their job included providing supervision to others, were asked about their experiences providing supervision. Most survey items were answered using 5-point Likert-type rating scales, and a relatively small number of questions sought respondents' views in the form of free text. The surveys were adapted with permission from questionnaires used in a UK research program investigating supervision for vocational trainees (Grant, Kilminster, Jolly, & Cottrell, 2003).

The South Australian questionnaires were distributed through members of the SA IMET Health Advisory Council and its committees, who forwarded links to the online surveys to their professional and informal networks. Survey recipients were asked to forward the link to doctors in their own networks. Data were collected between September 2010 and February 2011; this period included the distribution of emailed reminders through the networks described. Data were gathered electronically by SPSS Inc. and returned to SA IMET in spreadsheet form.

Results

RESPONDENTS

Ninety-three responses to the medical student questionnaire were received; findings from these participants will be described elsewhere. The survey distributed to trainee medical officers was answered by 185 individuals; twenty-seven doctors in their first postgraduate year (PGY1, or interns), 53 doctors in their second, third and fourth year of prevocational training (PGY2-4), and 99 from doctors engaged in vocational or specialty training programs (registrars). PGY1s, PGY2-4s and registrars (when referred to collectively) are described in this report as trainees or trainee medical officers.

Six trainee medical officers did not provide information regarding their level of training and so could not be included in many of the descriptions to follow.

Two hundred and fifty one senior doctors responded to the survey. Almost all of the senior staff (228/251) nominated one or more specialty colleges with which they held fellowships; the senior doctors are described collectively as consultants.

Response rates

The means of survey distribution precluded calculation of true response rates since it is not possible to determine how many individuals received the survey. Dividing the number of responses gathered from doctors at each level of training by the total number of doctors at that level of training in South Australia was the method used to generate the figures shown in Table 1.

Table 1 Rates of survey response among doctors in South Australia (SA).

Level of training / seniority	Surveyed n	SA total [a] N	Response rate [b] %
PGY1	27	230	11.7
PGY2-4	53	300	17.7
Registrars	99	1164	8.5
College Fellows	228	3573	6.0
Trainee, level of training unspecified	6	n/a	n/a
Senior doctor, fellowship(s) (if any) unspecified	23	n/a	n/a
TOTAL	**436**	**5267**	**7.7** [c]

[a] Medical Training Review Panel 14th Report (2011). Some figures approximate due to data quality issues.

[b] Number of respondents divided by State total at same level of training.

[c] Rate calculated where respondents (n=407) specified level of training/college fellowship(s), not total surveyed.

n/a Not applicable.

Approximately 8% of South Australia's medical officers responded to this lengthy survey (comprising over 300 questions). This is comparable to the response rates reported for the 20-item 2009 Australian Medical Association (AMA) Junior Doctor Training Education and Supervision Survey (distributed to 5700 junior AMA members, of whom 912 (16%) participated) and the 55-item 2010 AMA Specialist Trainee Survey (538 surveys (5.1%) returned from a population of 10,649 registrars). Both AMA surveys were electronically disseminated via the AMA Federal Secretariat.

DEMOGRAPHICS

Age and gender

Among the trainee medical officers, the majority of respondents (64% overall) were female (82%, 58%, and 61% of PGY1, PGY2-4 and registrars, respectively), and between two-thirds and three quarters of each group were aged 24-34 years. Sixty three percent of the registrars were in advanced training.

Two thirds of the consultants (67%) were male. The consultants were most commonly aged 45 to 55 years (38%), and just over half (57%) had held a senior position in Australia for more than 10 years.

Most respondents were domestic graduates, having received their initial medical qualification in either Australia or New Zealand (PGY1: 89%, PGY2-4: 80%, registrars: 67%, and consultants: 78%).

Work context

Respondents in their first postgraduate year were employed in the kinds of facilities with accredited PGY1 training positions. There was a greater diversity of employment settings among more senior trainees and among consultants; Table 2 shows the types of healthcare facility in which respondents were employed. To prevent the possibility of respondents being identified, results are not given for individual facilities.

Table 2 Types of healthcare facility in which respondents primarily employed.

Type of healthcare facility	PGY1 %	(n)	PGY2-4 %	(n)	Registrar %	(n)	Consultant %	(n)	ALL %	(N)
Large hospital (500+ beds)	70	(19)	70	(37)	48	(47)	32	(80)	43	(183)
Medium hospital (150-499 beds)	19	(5)	21	(11)	42	(42)	41	(103)	37	(161)
Other metro hospital (1-149 beds)	4	(1)	..	..	3	(3)	5	(13)	4	(17)
Regional/rural/remote hospital	7	(2)	8	(4)	1	(1)	2	(6)	3	(13)
Private practice	..	..	..	..	..	..	6	(14)	3	(14)
General Practice	..	..	2	(1)	2	(2)	2	(4)	2	(7)
Other*	..	..	..	..	4	(4)	4	(11)	4	(15)
No answer given	..	..	..	..	..	..	8	(20)	5	(20)
TOTAL	100	(27)	100	(53)	100	(99)	100	(251)	100	(430)

Note: Due to rounding, percentage totals may not add to 100.

 * Community health centre, government facility or university

 .. No responses for this category

Specialties and areas of medicine

Most specialties were represented among the colleges with which trainees were registered (or in the case of prevocational trainees, with which they were intending to register), and with which the consultants held fellowships.

The respondents worked in a diverse range of areas; these are shown in Table 3. **Error! Reference source not found.**

Table 3 Areas of medicine in which respondents worked.

Area of work [a]	PGY1 n	PGY2-4 n	Registrar n	Consultant n	ALL N
Medicine	6	17	16	55	94
Emergency / ICU / Anaesthetics	1	17	9	41	68
Surgery	5	12	13	36	66
Psychiatry / Mental Health	2	1	26	27	56
Paediatrics	..	2	16	27	45
Obstetrics and Gynaecology	3	1	11	16	31
Dermatology	..	..	2	8	10
General Practice	1	2	2	3	8
Pathology	..	..	2	6	8
Ophthalmology	..	..	1	5	6
Radiology	..	..	1	2	3
Clinical Education	..	..	..	2	2
Pain / Addiction Medicine	..	..	..	2	2
Palliative Medicine	..	..	..	1	1
Rotations [b]	9	..	..	..	9
No answer given	..	1	..	20	21
TOTAL	**27**	**53**	**99**	**251**	**430**

[a] Some areas of work were grouped (e.g., Emergency / ICU / Anaesthetics) into single response option

[b] Only PGY1 trainees could select this option

.. No responses for this category.

SUPERVISORS AND SUPERVISEES

Trainee medical officers provided information regarding the supervision provided to them. Consultants, and the trainees who indicated they provided supervision to others, were asked about the supervision they provided.

Sources of clinical supervision

The role descriptions of the person who provided most supervision to the trainee medical officer respondents are shown in Table 4. Each doctor in training could nominate one main supervisor.

Table 4 Person nominated as most closely supervising doctors in training (PGY1, PGY2-4 and registrars only).

Main supervisor	Respondents		
	PGY1	PGY2-4	Registrar
Consultant	26 %	55 %	93 %
Registrar	70 %	40 %	1 %
General Practitioner	4 %	2 %	2 %
Educational Supervisor (e.g. DCT)	..	2 %	4 %
Nurses	..	2 %	..
TOTAL	100 %	100 %	100 %

Notes: Trainees could select one response only.

Columns may not add to 100 due to rounding.

.. No responses for this category

Supervisor availability

Rostering impacted supervisors' availability to those they supervised, *"especially when there's two timetables to consider between the supervisor and trainee"* [PGY2-4], yet workloads often precluded adequate interaction even when both were present. Nevertheless, having a supervisor around was greatly valued by trainees.

> *"(Facilities should) make supervisors be PHYSICALLY available on site, not just say they're available"* [PGY2-4].

Most doctors in training reported they were available to their supervisor to a greater extent than their supervisor was available to them (PGY1: 63%, PGY2-4: 51% and registrars: 52%), although a significant proportion at each level of training (37%, 42% and 42%, respectively) indicated that their supervisor's availability matched their own. Many consultants indicated that they felt they should be more accessible to their trainees than clinical workload permits.

> *"Although around, I remain very busy and it may not always be possible for trainees to access me for long enough"* [consultant].

Providing supervision to others

Seventy percent of PGY1, 55% of PGY2-4, and 64% of registrars reported their current role included providing supervision.   While the supervision was always provided to a trainee of more junior rank (or a student), the "acceptable" extent of relative seniority within a supervisory relationship was questioned; several trainees emphasised the need for supervision to be provided by a significantly more senior clinician, *"preferably > 2 years 'ahead' of those being supervised"* [registrar], particularly in acute clinical care settings.

> *"While tutorials and bedside learning on the wards are definitely appropriate at my (PGY2) level, overseeing other doctors - particularly in a busy ED - is NOT appropriate"* [PGY2-4].

Many respondents expressed the understanding that providing supervision to more junior doctors was an intrinsic part of being a medical officer; *"Anyone in medicine is really supervising in some capacity"* [PGY1], although it was noted some senior clinicians avoided these responsibilities.

> *"There is an expectation that all doctors will teach and supervise"* [consultant].

> *"Supervision is not adequately shared and that fact is not enforced by the institution. Clear contract conditions and guidelines plus enforcement would help"* [consultant]

The average (mean) proportion of clinical time that was spent supervising increased with level of seniority: PGY1 (10% of clinical time), PGY2-4 (19%), registrars (22%) and consultants (24%). More than half of the respondents at each level of seniority (74%, 59%, 57% and 57%, respectively) felt they should spend more time supervising than they currently do.

Among trainees, one in three among each group reported that four or more factors (from a possible 14) caused them significant or great difficulty when providing supervision. For consultants, one in five reported 4 or more factors causing this level of difficulty.

The next section of the report presents key findings arranged by the themes shown in Figure 1.

SAFETY FOR PATIENTS AND TRAINEES

"Safety first, then education" [PGY1].

Patient safety was rated the most important purpose of supervision by consultants and by junior doctors at each level of training; this priority was also reflected in written responses. The contribution of good clinical training to patient safety was also emphasised.

"Teaching/learning is an integral part of patient care and safety, not a sideline issue" [registrar].

Prevocational trainees saw the effect supervision has on enhancing patient outcomes and safety most acutely, 38% of prevocational trainees reported that supervision had a very large effect on patient outcomes and safety, compared to 27% of students, 27% of registrars and 24% of senior doctors.

In recognition of the importance of this topic, thematic analysis was applied to the survey's text responses noted as having reference to safety. The first and dominant theme was the safety of the patient, who must not be harmed as a result of trainee medical officers' inexperience or lack of knowledge. Trainee safety was the other dominant theme; many instances in which the patient and trainee safety were presented as tightly linked; situations that were unsafe for patients were almost by definition unsafe for junior doctors.
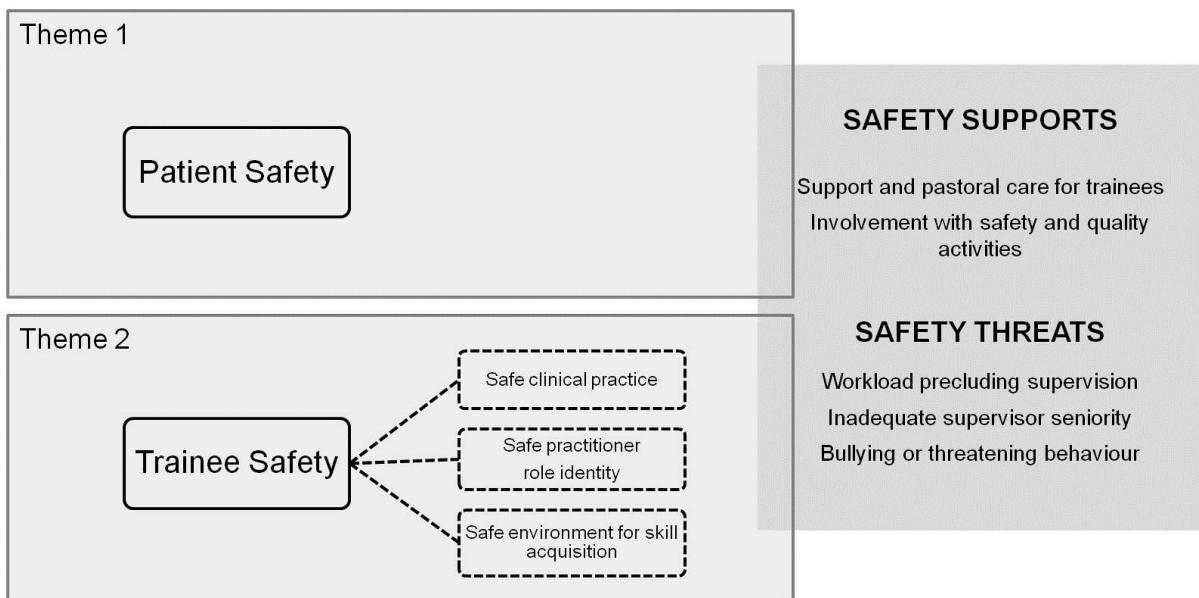

Figure 2 Safety-related themes derived from text responses.

Trainee safety comprised three essential components, which could be described as "what I do" (safe clinical practice on the part of the trainee), "who I am and will become" (reflecting their role identity as safe doctors and in the future, safe senior doctors), and "where and how I learn" (a safe environment

for skill development). These concepts were essential and contributory to one another; for example, a supportive learning environment was repeatedly paired with the ability of trainees to gain the knowledge and skills required to become a safe practitioner.

"To allow a trainee to develop their clinical skills in a non-threatening, supportive environment so that they can maximise their potential and learn safe and efficient practice" [consultant].

Where doctors tasked with supervision were not considered sufficiently "more senior", respondents perceived threats to safety.

"Leaving junior medical staff to oversee other junior medical staff is dangerous, for both doctors and patients" [PGY2-4].

Pastoral care and personalised support for trainees was identified as among the factors supporting safety, as were opportunities to be involved with quality and safety activities such as death reviews and critical incident investigations. The rating scale data revealed very few trainees were receiving either significant or full coverage of pastoral care. Although registrars received more than other trainees (possibly as a result of their association with colleges and ongoing relationships with senior consultants in their field of specialty), only 13% reported receiving either significant or full coverage of pastoral care (compared to 7% and 4% of PGY1 and PGY2-4). Moreover, in a number of cases, registrars questioned the depth of the apparent support offered by their supervisors.

"I have found them superficially supportive but not actually so" [registrar].

In some contrast, 20% of consultants reported delivering full or significant coverage of pastoral care to their trainees; this difference may reflect the practices of these particular consultants (and the experience of these trainees) rather than a more general mismatch of beliefs.

Support for trainees such that they feel safe was repeatedly noted as essential for skills development.

"(Supervision should) provide a facilitating atmosphere where the trainee feels safe and secure to further build on their abilities and capacities" [registrar].

Supervision is essential to a safe environment for skills development; inadequate supervision erodes clinical confidence among trainees who feel anxious as to *"whether we are doing the right thing by our patients"* [PGY2-4]. Without feedback, trainees are deprived of a means by which to calibrate their decision making and understanding of their level of clinical skill.

Few references were made to supervisor safety, other than their contribution to the safety of patients and their provision of supervision such that trainees feel safe. Nevertheless, one consultant pointed out the need for *"support for supervisors (such as) supervisor networks to share and improve on problems/issues"* [consultant].

SKILLS DEVELOPMENT: PROCEDURAL AND PROFESSIONAL

"Not only do we need to supervise trainees clinically with decision making, we need to help them to make decisions and manage their clinical workload - how to delegate, how to prioritise etc." [consultant].

Of all of the supervisory activities, those that help to develop team work, communication and interpersonal skills were consistently rated among the least covered, as well as the least effective. Nevertheless, among respondents' comments, there were many references to the need for skills that were not specifically clinical.

"I think we over-supervise procedures and under-supervise consultation" [consultant].

Role modelling was promoted as a powerful influence on trainees' acquisition of non-clinical skills, and for some respondents, the supervisor being a role model was among the primary purposes of supervision.

"Role modelling; most of us learn by observation and imitating. Engender academic rigour, confident decision making and a joy in Medicine!" [consultant].

Registrars and PGY2-4 level trainees placed a higher importance on the supervisor and trainee working together and observing each other (71% and 68% indicating this as having significant or great importance) than PGY1 trainees (59% reporting significant or great importance); while these are not large differences, it may reflect a higher value placed on role modelling among more senior trainees.

Role models for supervisory behaviour may have similarly powerful effects.

SUPERVISOR CHARACTERISTICS

Across all levels of trainees, the two factors rated as having the most important positive impact on supervision were characteristics of the supervisor:

- The supervisor having a commitment to teaching; and
- The supervisor having teaching skills.

Although 81% of PGY2-4 and 78% of registrars rated their main supervisor as having good or excellent approachability, a somewhat smaller proportion (59%) of PGY1 reported these levels of approachability in their main supervisor.

In addition to clinical competence and seniority relative to the trainee, characteristics such as being motivated and enthusiastic, approachable and accessible, were described as important.

Numerous comments from participants highlighted important supervisor characteristics. Several comments made reference to the supervisor having received training in supervision and clinical education techniques.

> *"(Supervisors should be) well educated and skilled, motivated, enthusiastic"* [registrar].

> *"(Supervisors should be) clinically competent and approachable, (have) attended a professional development course (including) instruction as to how to supervise and provide constructive feedback, (and be) aware of the educational needs of the people they are supervising"* [registrar].

> *"(Supervisors should have) 1. Appropriate education and qualifications; 2. Extensive experience in the field; 3. Understanding of educational principles; (and) 4. Passion for supervision"* [consultant].

> *"The most important criteria is whether the clinical supervisor has the burning desire to teach his/her students"* [consultant].

Having a good relationship between the supervisor and the trainee was found to be more important from the perspective of trainees than was the case from the perspective of providers.

The survey did not include questions that raised matters relating to supervisee characteristics, in contrast to there being numerous questions that directly or by implication prompted descriptions of desirable and undesirable supervisor traits. Nevertheless, a number of senior staff made reference to how trainees' characteristics impact the success or otherwise of supervisory relationships.

> *"People who are keen to learn and who have good interpersonal skills are usually very easy to supervise and guide"* [consultant].

Several other consultants also made reference to trainees' level of interest influencing supervision.

Having a "*commitment to teaching rather than simple service provision*" was given as protective against organisational priorities that tend to reduce teaching. The same consultant cautioned that clinical supervision can be compromised in circumstances in which supervision is provided by "*a head of service who may put the service's needs ahead of the trainee's*" [consultant].

Willingness on the part of supervisors was cited many times as being very influential: *"Most senior clinicians can be good supervisors – if they want to be"* [consultant]. Yet even where senior staff are committed, enthusiastic and have passion for the role, pressures of time were noted as having an undeniably profound impact.

> *"People are keen to teach and share their knowledge but there are too many patients... everyone is feeling pressure to work harder"* [PGY1].

ORGANISATIONAL INFLUENCES

Finding time to supervise posed the greatest difficulty among the given negative impacts on supervision. This was the case for trainees at all levels who had supervisory responsibilities, as well as for the consultants, and the problem was echoed in many respondents' comments.

> *"(We need) more time to learn from the masters! There is just not enough time to glean knowledge from experts."* [PGY1].

Restrictions imposed on junior doctors' working hours were cited by some senior staff as a barrier to learning, stating that as a result of these restrictions, *"ensuring adequate clinical experience is increasingly difficult"* [consultant].

The culture of the employing facility was noted for its effect on supervision. The *"ethos of the institution supporting training not just service provision"* [consultant] was noted as having potential for very positive impacts on supervision; ideally, workplaces encourage an *"atmosphere of learning"* [consultant], wherein supportive communities of practice have the opportunity to thrive. Nevertheless, workplaces also have the potential to negatively influence supervision, where facilities focus on service to the exclusion of training; such workplaces were described as "healthcare factories" [consultant].

It was also noted that workplaces had not made allowance for increasing numbers of students and trainees.

> *"Time allocated to supervisors has not changed with the increase in clinical workload and demand from increasing numbers of medical students and inexperienced trainees"* [consultant].

Some consultants reported that supervisory workload was avoided by some (other) senior staff; suggestions to address this included institutional enforcement of supervisory responsibilities, clear contracted requirements and rostering strategies. Additional remuneration for supervisors did not always result in trainees receiving the input they need; several consultants noted that extra senior staff were needed.

> *"Having an extra numerary senior clinician to teach and supervise would be ideal"* [consultant].

Several respondents mentioned frustrating role-conflicts associated with pressure applied by organisations.

> *"We are 100% employed clinically, but in addition need to supervise and educate, and be supervised and educated ourselves. It can be overwhelming"* [registrar].

> *"We are under constant pressure to meet KPI'S but also under pressure to increase supervision and it feels like we are being pulled from 2 directions"* [consultant].

FEEDBACK AND ASSESSMENT

"Know the difference between constructive feedback and destructive turn off" [consultant].

The ability to provide constructive feedback consistently ranked among the most important positive impacts on supervision, and needing more feedback (particularly on the job feedback) was included in many respondent contributions. Feedback should be constructive and ideally *"based on specific observations"* [consultant]. How feedback is delivered is clearly very important. Many respondents wrote about experiences they had had or witnessed where supervisors belittled or humiliated trainees in response to detected failures on the part of the trainee.

Providing anonymous feedback to supervisors did not rank highly among the positive impacts on supervision either from the perspective of supervisors or trainees, although the benefits of providing feedback to supervisors were mentioned by many senior staff. This suggests that better means could be devised for the delivery of feedback to supervisors; many trainees were understandably reluctant to offer negative feedback to supervisors, yet also saw the value in this activity.

"Trainees should be able to evaluate supervisors' performances more frequently" [registrar].

The absence of feedback from senior trainees or consultants perpetuated some poor supervision methods from consultants who *"have little interest in supervision or training and do not receive feedback by registrars or peers in regards to their own professional or educational skill set"* [registrar].

Trainees at each level rated monitoring and assessment of the trainee throughout the rotation as more important than the supervisor having knowledge of the assessment processes for specific levels of trainee, or a knowledge of assessment tools. This finding is consistent with this notion of feedback being part of an ongoing learning cycle, not a discrete 'occasion' of supervision.   One registrar expressed frustration with supervisors who *"provide a lot of constructive feedback but don't monitor progress and acknowledge improvement in the areas they critiqued"* [registrar].

Many trainees complained about assessments being conducted by senior staff who had had few occasions of interaction with them.

"The senior doctor who has observed the trainee should do the appraisal for the trainee rather than the designated supervisor who has had no contact with them" [PGY1].

Both under-evaluation of good trainees, and under-performing trainees slipping through the cracks were cited as negative consequences of appraisals conducted by staff with insufficient knowledge of trainees. Conversely, some trainees were reluctant to engage with the supervisor who was conducting their assessment when they needed help or feedback, because *"if I ask a question from the registrar I will find it in my appraisal as a weakness"* [PGY2-4].

 "I find hard to admit problems to your supervisors if they are also your assessors" [registrar].

TRAINING

"I am not convinced you can make a great teacher - but you can improve a poor one via training"
[consultant].

A significant minority of respondents had participated in training relevant to supervision. The most commonly-attended training was Teaching On The Run (TOTR) workshops; these were considered very useful.

A significant number of consultants had received training in supervision methods through their specialty colleges. The College of Dermatologists was noted to offer outsourced training that was considered very useful, and numerous instructor training courses offered by the College of Surgeons had been undertaken.

A small number of consultants and senior registrars had participated in the Professional Development Program for Registrars. Lack of supervisor training had a particularly negative impact on registrars; forty percent of registrars reported this caused them significant or great difficulty as a supervisor, compared to the 26% of prevocational trainees and 14% of consultants who reported this level of difficulty. The lack of supervisor training should be differentiated from having knowledge of supervision and teaching methods, the latter posing significant or great difficulty to 26% of registrars and 23% of prevocational trainees with supervisory responsibilities, and 11% of consultants.

Almost all respondents (96% of PGY1, 96% of PGY2-4, 93% of registrars and 93% of consultants) felt it was important to receive clinical and educational supervision training.

Suggested training formats and the proportion of respondents endorsing these for clinical/educational supervision training are shown in Table 5.

Table 5 Ideal formats* for clinical / educational supervision training.

Training formats	Proportion of respondents (%) endorsing training format				
	PGY1	PGY2-4	Registrars	Consultants	ALL
Workshops	56 %	74 %	72 %	79 %	75 %
Formal courses	44 %	50 %	56 %	57 %	55 %
Written guidelines	44 %	34 %	50 %	43 %	44 %
e-learning	32 %	42 %	36 %	48 %	44 %
Informal advice	48 %	34 %	32 %	35 %	35 %
Modular programs	20 %	24 %	24 %	34 %	29 %
One-on-one training	12 %	26 %	27 %	14 %	19 %
Any format(s) endorsed	93 %	94 %	91 %	87 %	88 %
3 or more formats endorsed	41 %	47 %	50 %	53 %	51 %

* Respondents could nominate more than one format.

Small group learning within a relevant community of practice, periodic publications such as newsletters as well as recommended reading from journals were also suggested as formats for training.

The enthusiasm for training among the respondents is demonstrated by the number of formats in which supervision training would be welcomed, or in the words of one PGY2-4, *"ANY education would be readily received!!!"*. Nearly one in three of the respondents who felt it was not important to receive training went on to endorse one or more formats as ideal.

Workshops were clearly the most popular format for training in clinical/educational supervision, preferred by three quarters of respondents; some respondents expressed particularly strong views about this.

> *"Anything other than workshops is like reading a textbook - useless, supervising is an active process and should be discussed and illustrated"* [registrar].

The theme of time and the need to account for the time involved with supervision-related activities was again apparent in the context of training.

> *"There would need to be time allocated for this, not be expected to do it in my own time"* [consultant].

The question of whether training in supervisory skills should be mandatory attracted mixed views; while some respondents felt this would increase uptake, and have associated improvements to supervision practices, others took the view that forcing training on clinicians would be unhelpful.

> *"If (training programs are) available, they should not need to be compulsory as this will not encourage people"* [PGY2-4].

Recognition of supervisor training by Continuing Professional Development schemes was proposed as a means of increasing participation.

Increasing the availability and uptake of training in supervision techniques was noted for its potential to effect the distribution of supervisory load across a greater number of senior staff, which is particularly relevant in the context of increasing numbers of trainees.

A large proportion of trainee medical officers reported their role included supervising the clinical work of trainees more junior than themselves, even among those in their first postgraduate year who were tasked with responsibilities such as *"ensuring that medical students learn how to go about doing basic intern tasks"* [PGY1]. They recognised that many of the required skills, such as *"(being) adept at imparting knowledge to others less experienced"* [PGY1] did not necessarily come automatically: *"Not everyone can do it!"* [PGY1].

In recognition of these kinds of struggles, many respondents suggested relevant training in supervision skills be provided at all levels of training, and be a part of all prevocational and vocational training programs, rather than being largely available to doctors at consultant level, if it was provided at all.

"(There should be) training on how to supervise... for all trainees once they start to supervise" [registrar].

Providing training in supervision techniques to junior doctors has potential to improve the performance and associated confidence levels of junior doctors tasked with these responsibilities, as well as affording the enhanced patient care and improved skill acquisition associated with quality supervision.

PARALLEL RESEARCH IN VICTORIA

A parallel study, using the same questionnaires, but delivered in paper and pencil format was conducted by Monash University in Victoria. Although a systematic comparison of the data has not been done, the highlighted themes of safety and finding time to supervise were shared between both sites, and the Victorian study found similarly low levels of activity relating to personal and professional skills development. Interestingly, senior medical staff in both states report levels of supervision activities that are considerably higher than the trainees report receiving. The Monash research included a detailed sub study in relation to the experience of IMGs, which has not been conducted in South Australia.

DISCUSSION AND RECOMMENDATIONS

A large sample of South Australian doctors shared their views on clinical supervision for doctors in training. Constructive, on-the-job feedback was emphasised as crucial to advancing junior doctors' skill acquisition. In contrast, input from supervisors that was variously belittling, nonspecific or absent was clearly detrimental. The trainee's role in accepting feedback also factored into this process. While anonymous feedback for supervisors attracted mixed views, extending (or establishing) means through which supervisors can improve, via gaining greater knowledge of their current performance, emerged as an aspect of local practice deserving further exploration.

The benefits of quality supervision were many: trainees effectively and safely contributing to patient care workloads, contributions which increased concurrent with the development of their skills, both in terms of clinical practice and the supervision of other junior doctors

In most instances where personal or behavioural characteristics were referred to, these were those of the supervisor, not least due to the number of questions either directly or indirectly inviting comments in this vein. Commitment to teaching, enthusiasm, openness and accessibility were highly valued traits seen as having a positive impact on supervision quality. While the onus clearly and appropriately rests with the supervisor to shape supervisory interactions, interested trainees with good interpersonal skills were seen as positively impacting supervision. Given the finding that activities intended to develop interpersonal skills received among the lowest levels of coverage, it is unclear where (besides role modelling) these skills are to be learnt; training for junior medical officers in these kinds of areas may need to be provided in contexts external to the clinical supervision setting. The down-prioritising of non-clinical skills is likely to result in large part from ongoing battles to find time for supervision. Organisational factors, particularly those relevant to protecting time for supervision were very frequently cited as having strong impacts, particularly on the quantity of supervision that could be provided.

Among the primary strengths of this research were respondents' comments submitted as free text; these insights contributed greatly to understanding how supervision is experienced as recipients and delivered by providers. Responses to the rated survey items tended for the most part to be strongly skewed toward agreement, particularly with regards positive impacts on supervision, where the considerable majority of responses indicated that all items shared significant or great importance. Differentiating between the relative items was often difficult due to the often minimal differences in response distributions for the individual items. Although the nature of the ratings data posed these problems, the variability between supervision practices was repeatedly noted in the answers provided as text.

"Wide range of variability depending on the term and team you are working with" [PGY1].

Response rates were comparable to other large-scale studies in this area. A large number of senior medical staff dedicated a significant period of time to completing the survey, and a large amount of information was provided by these respondents. It is acknowledged these respondents would likely share a significant interest in junior doctor training and as such their views and reported practices may not represent those of a broader consultant group; it is possible (even likely) that a higher level of supervision is provided by these doctors than might more typically be the case. Conversely, relatively few responses were gathered from trainees in their earlier postgraduate years; the responses that were gathered, moreover, may in some cases be from trainees who took the opportunity to describe supervision that was lacking. Much can be learnt from these respondents, particularly with regards to areas requiring address.

Quality clinical supervision is critical to the delivery of safe and appropriate patient care by junior doctors, and to the ongoing development of these doctors' clinical and professional acumen. For many or most trainees, this ongoing learning must take place alongside progressively greater responsibilities for overseeing the actions of doctors more junior to themselves, and contributing to these more junior colleagues' learning. Supervision workloads are shouldered unevenly and the quality of supervision provided varies widely, both between healthcare settings and between individual providers; improving supervision practices via supervisor training found emphatic support among survey respondents at all levels of training and seniority. Providing supervision training to all levels of trainees should be considered. Training may also be required to develop trainees' non-clinical skills, given the relatively low levels of coverage for developing these aspects among junior doctors.

Strongly worded views regarding the insufficient time available for clinical teaching were prevalent, and supported other data indicating that this represented the most significant barrier to teaching and supervision, particularly in terms of the amount that could be provided.

> *"It's forgotten that it is a teaching hospital due to being bogged down with clinical and system demands for ever-greater service through-put. Both (teaching and clinical services) are required, but if only the latter then it's a health-care factory, not a teaching centre"* [consultant].

In the present context of increasing trainee numbers, problems relating to insufficient time for supervision will worsen without the allocation of protected time and resources essential to junior doctor education. Case discussions and teaching clinical techniques were among the activities noted for their effectiveness in supervision, with constructive, on-the-job feedback emphasised as particularly crucial. Feedback was among several areas respondents flagged for their relevance to skills development for both supervisor and supervisee. Recognition of the often mutually beneficial nature of the supervisory relationship was apparent in many contributions to this research, including the description offered by a palliative care specialist of additional factors in support of quality supervision:

> *"One's own personal development is enhanced; exposure to keen young colleagues stimulates one's own interest, and prevents cynicism, complacency, and the development of Alzheimers"* [consultant].

These findings have highlighted some potential areas for development, and prompted the following recommendations:

1. SA IMET work in partnership with Local Health Networks to develop training programs relevant to increasing skills in clinical teaching and supervision (for example, providing constructive feedback, or addressing trainee underperformance). Variations of the training program should be devised to suit the needs of senior clinical staff, as well as the needs of junior doctors at each level of training, who themselves provide supervision.

2. SA IMET to develop and organise the delivery of training (outside the clinical setting) for critical non-clinical skills (for example, managing work flows and prioritisation), which can be refined in the workplace through role modelling.

3. Uptake of training designed to facilitate growth of supervisor skills should be promoted by individuals involved in medical education, fostering of a cultural shift toward valuing clinical supervision in South Australia.

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