ANZCA
FPM

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Dear Helen,

Measuring supervision: Draft guidance to support the Model Standards – ANZCA feedback

Thank you for the opportunity for ANZCA to provide feedback on the associated *Attachment A: Measuring supervision: Guidance to support the Model Standards for Specialist Medical College Accreditation of Training Settings* consultation draft document.

The value and importance of high-quality supervision, both clinical (including patient safety) and educational is a key priority for ANZCA. Anaesthetists operate in a high risk, complex and dynamic environment that necessitates trainees to demonstrate the appropriate knowledge and skills (especially airway, vascular access and resuscitation skills) through a formalised assessment prior to moving beyond direct 1:1 supervision. Moving to even more distant supervision is predicated on completion of workplace-based assessments (WBAs) to demonstrate clinical competence to do so.

All fellows of the college working in government-funded hospitals are able (and expected) to supervise trainees. The college expects fellows to supervise trainees, although the level of supervision is variable. No trainee would work unsupervised, even at the most senior level. This is a requirement of training, mandated by the college and consistent with the approved Australian Medical Council accreditation standards.

Supervisors don't only answer to the colleges but also to the training providers to ensure trainees are appropriately supervised clinically and patients are not put in harm's way by trainees who have yet to acquire the relevant experience and competence.

ANZCA finds this guidance document acceptable, reflecting the variation across colleges with respect to supervision, however ANZCA may still require college specific requirements regarding supervision. The college is also satisfied with the delineation of clinical and educational supervision. Some feedback on the consultation document is identified below.

Clause	Topic	ANZCA comments
2.1	Model standard numbers	**Correction:** This clause is incorrectly written as 3.1 and should be 2.1. **Suggestion:** Model standard numbers are listed in the paragraph however many readers wouldn't know the standards' narrative, suggest an appendix of mentioned standards is included, for completeness in one document. Relates to references in clauses 8-10 as well.
4.2	Clinical supervision	**Document reference:** *"Clinical supervision can be undertaken by specialist medical practitioners of the same, or* ***different specialties****, more senior trainees,* ***nursing, midwifery and other allied health staff*** *as appropriate to the clinical practice being supervised."*

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		Feedback: Our trainee cohort have concerns and considers it inappropriate for ANZCA trainees to be supervised by other specialties for clinical anaesthesia time such as surgeons, ED physicians, medical physician or procedural specialists (e.g. gastroenterologists, cardiologists etc), or nursing, midwifery or allied health staff for a number of reasons: 1. **When anaesthetic trainees request a consultant for assistance, particularly in the after-hours settings**, this is often for time-critical (life or limb threatening) situations where any delay in treatment may lead to significant patient morbidity or mortality. They therefore need clinical supervisors with the skills to resuscitate patients and assist in these settings, whilst adhering to college guidelines. As they become more senior and develop more advanced airway and resuscitation skills, the threshold for requesting prompt clinical support increases. Therefore, there is an expectation for clinical supervisors to have skills and knowledge in excess of ours. 2. **Anaesthesia is a procedural-heavy specialty**, where trainees are required to perform intubations, central venous access, neuraxial anaesthesia, regional anaesthesia (and plenty more), sometimes under emergency/time-critical circumstances. It is therefore inappropriate for clinical supervisors to supervise ANZCA trainees in procedures outside of their scope of practice. Furthermore, remote supervision for procedures is inappropriate and risks patient safety. There are potential regulatory implications for clinicians (both medical and non-medical) who are seen to operate outside of their scope of practice, and it puts nursing and allied health colleagues particularly at risk, along with patients. 3. **Medicolegal implications.** In our specialty our trainees may be caring for patients in extremis with imminent life or limb threatening injuries. Furthermore, adverse patient outcomes can occur unpredictably, even in “low risk” patients or surgeries (e.g.: unexpected life-threatening anaphylaxis or can’t intubate/can’t oxygenate scenarios). These unfortunate incidents in seemingly “low risk” patients are well documented in the medical literature worldwide. In the event of patient mortality or a major adverse event, what are the medicolegal implications for a trainee who undertook care of the patient under the clinical supervision of a non-anaesthetic specialist, nurse, midwife or allied health colleague? On top of the emotional and psychological injury to the trainee, there may be potential medicolegal ramifications for trainees which have not been considered in the development of these supervision guidelines. 4. **Conflict of interest** - by putting trainees in a situation where their clinical supervisor may be the procedural clinician for that list (e.g. surgeon, gastroenterologist), therein rises a significant conflict of interest whereby anaesthetic trainees may not be able to escalate concerns regarding patient safety/appropriateness of anaesthetising the patient. They need a safe escalation pathway to their own clinical supervisors wherein objectivity is maintained when they are potentially concerned about the appropriateness of proceeding with a case from a perioperative/anaesthetic perspective. This compromises their ability as trainees to advocate

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		for their patients and can also lead to an imbalance in "multidisciplinary" discussions. There are nuances in risk stratification, and the college training is rigorous and world standard for a reason. By dismissing this, our role as a specialty in promoting perioperative patient safety is being undermined. This perspective may differ for other specialities, however we ask for the wording of the highlighted aspect of this statement to be reconsidered and edited/removed. This statement may have been included more in the interest of hospital/healthcare institution service provision and efficiency, rather than considering patient safety, or the education and wellbeing of ANZCA trainees. Our ANZCA trainees value high quality supervision and recognise that this is a core attribute of any anaesthetist who has gained fellowship within the college. They strive to uphold and learn how to provide high-quality clinical supervision to future ANZCA trainees. The college would accept supervision for other clinical time by these specialists where the specialists scope of practice matches what the trainee is expected to do.
4.2	Clinical supervision – in contact with trainees v role of teaching and training	**Document reference:** *"In a hospital setting, specialist medical practitioners undertake supervision as part of their normal duties, if they are practising alongside trainees."* **Query:** Does this mean all specialists in contact or working with trainees (as part of their employer determined role and responsibilities of teaching and training) regardless of being assigned as their 'clinical supervisor'?
5.1	Editorial	**Suggested insertion:** *"This guidance is based on the following **four** principles."*
8-11	Elements and evidence	**Feedback:** The college's accreditation committee and visitors will appreciate the specific examples of questions to ask in clauses 8-10, and the college will look at the way we incorporate the various measurements in section 11. **Suggestion:** If these will be referred to/used, perhaps including a numbering system may be beneficial.
8-11	Cultural safety	The college welcomes the inclusion of cultural safety in these documents.
8	Feedback to/about supervisors	**For noting:** The college supports trainees being able to provide feedback to/about supervisors in a way that does not compromise their training or career prospects. However, trainee advice is that the majority of educational supervisors they have encountered in their training have been excellent advocates of trainee wellbeing and a key point of support during stressful/distressing times. Whilst we feel that establishing safe, professional avenues for trainees to provide constructive feedback is important, we are also mindful of the stressors this volunteer workforce already faces.

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8	Remote supervision	The college already supports remote educational supervision - trainees working at satellite sites may have their supervisor of training at the parent hospital, not the satellite. Remote clinical supervision is referred to as level 4 supervision. When the college's trainees are working at level 4 supervision then all the staff working with our trainees at the time (i.e. surgeons, nurses, anaesthetic assistants) can provide feedback to the supervisor (e.g. through a multi-source feedback or informal channels) and can advocate for patients and trainee safety if they have concerns, however they are not supervising our trainees and shouldn't accept that kind of responsibility. As an acute care specialty, the college would unlikely support clinical supervision in anaesthesia being provided from a separate site. Who can be a supervisor is clearly defined (which doesn't include other specialties or health professionals).
9	Element 3 description	**Suggested insertion:** *"This element centres on whether the setting provides a **sufficient** level and quality of clinical supervision to ensure: patient safety is maintained; the trainee's clinical practice is supervised to the appropriate level of the trainee's competency **and speciality requirements**; and the supervision arrangements do not make the trainee feel unsafe."*
9	Element 3 clinical supervision measures	**Document references:** • Are trainees able to access clinical supervision (consultant, more senior trainee, **other appropriate clinician**) when needed to support appropriate and safe patient care? (2.2.1) • Do supervisors have the relevant skills and competencies? (Noting that it is **sometimes safe** and appropriate for more senior trainees, **non-specialist doctors, other specialists or allied health staff** to provide clinical supervision.) (2.2.1) **Feedback:** These statements are vague and it is not clear who decides what constitutes an "appropriate clinician" or when it is "sometimes safe" - if interpretation of this statement is left to individual hospitals or departments, trainees could be forced into a situation where they are uncomfortable with the provision of clinical supervision or feel that it compromises patient safety without an avenue to escalate. These statements seem to facilitate service provision rather than ensuring patient safety or trainee education and wellbeing. This perspective may differ for other specialities, however we ask for the wording of the highlighted aspects of these statements to be reconsidered and edited/removed. These statements may have been included more in the interest of hospital/healthcare institution service provision and efficiency, rather than considering patient safety, or the education and wellbeing of ANZCA trainees. Our ANZCA trainees value high quality supervision and recognise that this is a core attribute of any anaesthetist who has gained fellowship within the college. They strive to uphold and learn how to provide high-quality clinical supervision to future ANZCA trainees.

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9	Level of supervision provided	**Suggested insertion:** *"Do trainees have confidence in the level of supervision provided, or do they feel "out of their depth", i.e. that they are expected to do things without supervision that they are not yet competent to do?* ***This may include canvassing supervisors' perspective on this*** *(2.2.1; 2.3.1, 3.2.1)"*
10	Training settings to provide time for educational supervision	The document doesn't clearly and sufficiently articulate the need for health services/training settings to provide time for educational supervisors to undertake their necessary duties (e.g. non-clinical time, training to become a supervisor of training etc.). It is important for educational supervisors to be afforded allocated time away from service delivery to focus on this role.
10	Educational supervision sufficient time	"Supervisor ratios" refer to a minimum ratio of educational supervisors to trainees at a site, and thus the minimum amount of resources/clinical support time that a department must devote. This document outlines *"are educational supervisors provided with sufficient time to undertake educational supervision tasks within their employed/contracted working hours?"* The college currently undertakes this kind of qualitative assessment, especially asking if there is capacity to flex up available time at the start/end of terms for meetings with trainees. Having a ratio, or a target expressed as such, is much easier to measure and justify.
11	Evidence	**Include suggested evidence point:** *"Training setting data on safety and acceptability of remote supervision."* (rather than reliance/perspective from the remote supervisor or the trainee), to be included after the following point: "The facilities available at the setting to enable remote supervision."

Regards,

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CEO

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