The Royal Australasian College of Physicians

Australasian Faculty of Rehabilitation Medicine

REHABILITATION MEDICINE ADVANCED TRAINING PROGRAMS

GUIDELINES FOR CLINICAL SUPERVISORS AND TRAINERS

For distribution at AFRM Supervisor Education Workshops

To be used in conjunction with:
Rehabilitation Medicine Training Requirements Handbook 2010
Rehabilitation Medicine Advanced Training Curriculum
RACP Professional Qualities Curriculum

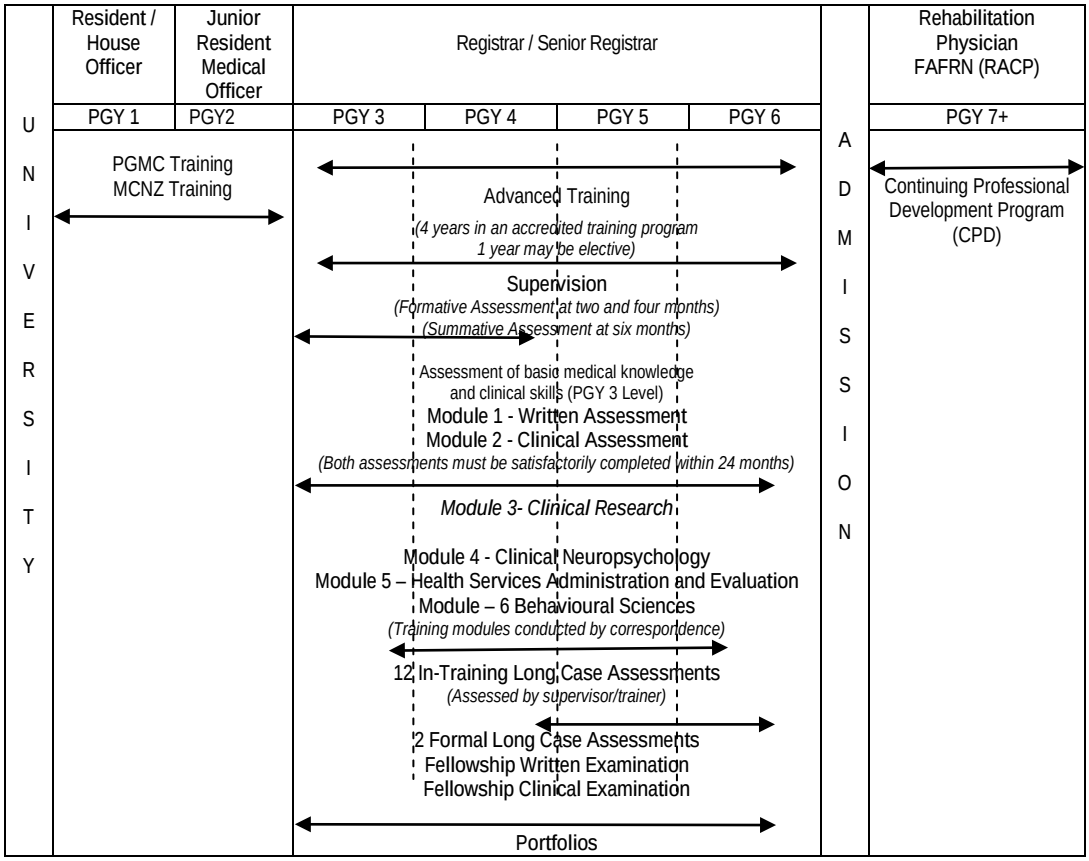
CONTENTS

ATTACHMENTS

OVERVIEW OF TRAINING AND OUTCOMES

Admission to Fellowship of the Faculty requires completion of all training and examination requirements as follows:

- Satisfactory completion of four years of supervised training in Rehabilitation Medicine in an accredited training program
- Satisfactory completion of Modules 1 and 2
- Successful completion of External Training Modules in:
  i) Clinical Research – Module 3
  ii) Clinical Neuropsychology – Module 4
  iii) Health Service Administration and Evaluation – Module 5
  iv) Behavioural Sciences – Module 6
- Satisfactory completion of other training modules, as required, such as FIM training
- Satisfactory Supervisor's Reports, including 12 satisfactory In-Training Long Case Assessments (ITLCAs). *The Faculty Education Committee regards the Supervisor's Report as an important component of the training program. All trainees will be required to submit Supervisor's Reports to the Faculty every six months*
- 2 Formal Long Case Assessments (FLCAs)
- Successful completion of the Fellowship Examinations
- Recommendation to Fellowship of the Faculty and award of FAFRM (RACP)



SUMMARY OF PROCEDURES FOR CLINICAL SUPERVISION

The purpose of the Rehabilitation Medicine Advanced Training Program is to build on the cognitive and practical skills acquired during previous training to produce a Rehabilitation Physician competent to manage complex patient problems or to provide advice on such patients to other medical practitioners.

The underlying philosophy of the training program is that trainees are self-motivated to learn. Provided there are appropriate opportunities for learning and observation, it is expected that clinical skills, knowledge and attitudes will develop by working closely with supervisors who provide formative and summative assessments. The standard of a Rehabilitation Physician is attained with and evidenced by satisfactory completion of all the assessment requirements and the Fellowship Examinations.

The fundamental principle of the Faculty's Rehabilitation Medicine Advanced Training Program is that it is carried out under supervision.

Trainee Nominates Supervisor

At the beginning of the training year each trainee is required to submit an **Annual Registration Form** requesting approval for the next two six-month terms of training. On this form the trainee provides information about two training positions and the names of the doctors who are to supervise them. Supervisors are not necessarily the most senior Consultant or the Head of the Rehabilitation Unit where the training is being undertaken. They should normally be the medical specialist who has the closest working relationship with the trainee for a significant period during the term.

Approval of Programs

The Teaching and Learning Subcommittee of the Faculty Education Committee approves those programs that are suitable and trainees are notified. The nominated supervisors are contacted to confirm the arrangements. Approval of a training program does not automatically ensure that the time will be accredited or certified as having been satisfactorily completed. Accreditation is dependent on the trainee having satisfactorily completed the training detailed in their application, with a satisfactory supervisor's report including the required In-Training Long Case Assessment scores and submission of a Trainee Term Evaluation Form. For trainees enrolled in the PREP Advanced Training Program it could also be dependent upon completion of a Learning Needs Analysis for the term.

Introduction to the Training Term - Learning Needs Analysis

Before the training term commences the supervisor should meet with the trainee to collaborate on the learning relationship that will take place during the training term. The trainee needs to first assess and identify their own personal learning needs using the online Learning Needs Analysis Form, which is linked directly to the learning objects set out in the Rehabilitation Medicine Advanced Training Curriculum and the Professional Qualities Curriculum. Then in collaboration with the Supervisor a learning agenda is formulated that reflects their individual and shared learning goals for that term.

In-Training Long Case Assessments

Two satisfactorily completed formative In-Training Long Case Assessments are required each term, ideally with the last evaluation being undertaken towards the end of the term. The scores for all in-training long case assessments are to be listed by the supervisor on the **Supervisor's Report Form** that is submitted to the Faculty Office at the completion of the training term.

Formative and Summative Assessment Interviews

Supervisors should regularly discuss progress with the trainee in order to resolve difficulties at an early stage. Supervisors are asked to conduct formative assessment interviews on three occasions during the term and provide feedback to each trainee, reflecting upon progress against the agreed learning goals identified at the beginning of the term on the Learning Needs Analysis

Form. On each occasion the supervisor and trainee should discuss both positive and negative aspects of the training experience and where performance in any area has been unsatisfactory, the supervisor must indicate remedial action to be taken. The next interview will address the effectiveness of such action, and the need for further action.

The Supervisor's Report Form is to be completed and discussed during the final summative interview towards the end of the term. Once signed the completed Supervisor's Report Form is to be forwarded by the trainee to the Faculty office to arrive within four weeks of the completion of the training term.

The Supervisor's Report

This report is one the Faculty's most important means of evaluation of the trainee's performance, so the comments, which should take into account the opinion of others with whom the trainee has worked during the term, are very valuable. Accreditation of the training time completed is dependent upon receipt of the completed form.

SPECIFIC FACULTY REQUIREMENTS FOR CLINICAL SUPERVISION

Orientation/Induction to the Training Term

The Clinical Supervisor must meet with the trainee on or before the first day of the term to define and discuss the following issues:

- the identity and availability of the Clinical Supervisor
- the identity and availability of clinical trainers and other Rehabilitation Physicians
- the identity and location of key rehabilitation team members (e.g. Nursing Unit Manager, PT, OT etc.), including the availability of junior medical staff

If the Clinical Supervisor, trainer/s or trainee expects to be taking leave at any time during the term, this should be disclosed and discussed at the earliest opportunity. Such leave includes conferences, courses, and other planned leave.

The trainee's specific responsibilities and timetable

The trainee should be advised of their clinical responsibilities, the Rehabilitation Physicians to whom they are responsible, and their obligations in respect of

- ward rounds
- initial assessments of requests for consultation
- team meetings
- family interviews
- out-patient clinics
- community work
- overtime shifts
- teaching of junior staff and medical students
- research
- quality management
- administrative functions

In some situations, the trainee may require geographical orientation to the hospital campus, including library, other facilities/amenities, personal lockers and car parking.

The trainee's educational commitments

To facilitate teaching and learning, the trainee must have reasonable access to on-site and off-site educational resources, including texts, journals, and on-line information technology. The trainee's clinical responsibilities should not prevent them from attending Faculty training events and other relevant educational activities.

There should be at least 60 minutes per week of dedicated face-to-face 1:1 teaching with either the Clinical Supervisor or another trainer, based as much as possible on patients or topics of

specific relevance. This teaching time should be in addition to clinical teaching and assessment in multidisciplinary settings, and directly didactic activities, such a journal clubs and tutorials.

In respect of clinical activities, the Faculty Education Committee (FEC) regards that a large part of the trainee's workload should involve decision-making, problem solving and team interaction at a level that mirrors that of a Rehabilitation Physician. While trainees may be required to undertake routine clinical clerking, the FEC expects that the Clinical Supervisor will monitor the trainee's workload, and ensure as much as possible that the trainee's clinical responsibilities are appropriately graded to the levels and goals of Advanced Training.

Dedicated face-to-face teaching time

What constitutes adequate supervised teaching during a training registrar's term at a training institution?

The Faculty Education Committee has determined that Clinical Supervisors and trainers should be providing at least one hour of face-to-face or direct teaching time per week, either personally or in groups of up to three trainees in settings with more than one trainee, in addition to whatever else is provided by the state-based training sessions.

If this is in a small group format then additional protected time must be set aside for personal contact with each trainee to enable individual feedback. This would be in addition to any general hospital Grand Rounds or other training (e.g. basic physician training sessions) and should be specific to the principles and practice of rehabilitation medicine.

It is recognised that this hour of training may take different forms. It is unreasonable to expect the supervisor of a registrar in a rural setting to provide a formal hour-long tutorial every week on a different topic. This may however, be able to be provided in a larger unit where there are a number of Rehabilitation Physicians.

An hour's teaching therefore has to be specific to rehabilitation medicine and be in addition to the day-to-day management of patients within the unit. It is best for this to be a flexible arrangement and for it to be discussed, documented and agreed to by all parties at the commencement of the term when a training agreement is negotiated.

It could therefore be specifically case-based, could involve general discussion of investigation reports or radiology investigations, or could be a generalised one-on-one discussion regarding examination technique or treatment approaches. It could be related to generalised topics such as applying for jobs, business practices associated with private practice, administrative issues and how to deal with them, or a multitude of other topics that have specific relevance to the principles and practice of rehabilitation medicine.

Ideally an hour should be set aside on a formal basis as that will guide both the supervisor and the registrar/s as to the importance of face-to-face teaching per week, or it may be completed in a number of sessions adding up to one hour's face-to-face teaching per week, if this fits best with the supervisor and/or trainee. It is emphasised however that teaching should be generalised and not directly related to a specific patient's management.

In addition to the Bi-National Training Program videoconferences, it is recognised that there are a number of state-based training sessions available. These vary between state to state in the scope of teaching subjects, frequency of meetings and it is recognised that not all trainees, especially trainees in New Zealand or in regional or rural settings, can attend these training sessions. These sessions are seen as additional to and not replacing, the one hour face-to-face or direct teaching to be done on a weekly basis.

In the AFRM training setting, as part of the accreditation process, the regularity, adequacy and relevance of the face-to-face teaching will be discussed both with trainees and with supervisors as part of a virtual site visit.

Monitoring and evaluating trainee performance

In the first weeks of a new term, it is necessary to liaise closely with the trainee during this 'settling in' period. A brief weekly meeting is advisable, to ensure that the trainee is fully aware of and is coping with their new responsibilities, is forming satisfactory relationships with staff, and is meeting the goals of their Learning Needs Analysis.

The dates of the formative interviews at two and four months should be scheduled for the term at the initial meeting with the Clinical Supervisor and trainee. The Education Committee regards these interviews to be of the utmost importance in monitoring the trainee's performance in all areas, and providing the opportunity for timely and relevant feedback. (See Sections: Effective Clinical Supervision: Performance Feedback; and Guidelines for Formative Interview)

Trainees should be advised that they will be continuously evaluated during the term and that feedback will be given at the formative interviews as well as the final summative interview on the basis of the agreed learning objectives, and that the observations and comments of relevant staff and team members will be canvassed in this regard.

It should also be possible for the dates of In-Training Long Case Assessments (ITLCAs) to be set at the beginning of term. It is preferable to schedule this type of assessment *before* each interview, as the observations by the assessor during the ITLCA may be relevant to the Clinical Supervisor's evaluation of the trainee's progress in specific areas such as *clinical assessment, diagnostics, and problem-solving skills*.

ITLCAs should not be undertaken *only* at the end of term, or *after* the term has been completed, as is sometimes the case. The opportunity for a Clinical Supervisor or Long Case Assessor to *directly observe* the trainee during the ITLCA is essential in providing specific feedback to the trainee regarding their clinical skills, and identifying areas of potential remediation during the term. Such opportunities are lost if the trainee does not undergo these assessments *during* the term.

LONG CASE ASSESSMENTS

The purpose of a long case assessment is to test the trainee's ability to deal with common clinical problems in Rehabilitation Medicine. It should focus primarily on the assessment and management of disability. Trainees being assessed are required to:

1. Identify, prioritise and discuss the patient's impairments and disabilities
2. Describe and discuss the patient's rehabilitation potential, and appropriate short-term and long-term rehabilitation management
3. Provide a legible written summary of their assessment and proposed management on the consultation request form provided

The reality of rehabilitation practice is that patients are seen by referral. Many have been extensively investigated, and the results of those investigations are usually available to the Rehabilitation Physician to assist in confirming the clinical features and in the formulation of a management plan.

Long case assessments should closely approximate the reality of clinical referral practice. This is achieved by:

- Providing the trainee with any relevant X-rays, medication charts or the results of other investigations.
- Giving the trainee a consultation request form on introduction to the patient. The consultation form will be written by the Rehabilitation Physician who is assessing the trainee, in a style common to that used in teaching hospitals when asking for a consultation from a Rehabilitation Physician. A space will be left on the consult sheet for the candidate to write a response to the consultation request.
- The case should normally be a new request for admission to Rehabilitation rather than a referral to / from another team member e.g. a Neurologist
- Hospital patient files will NOT be given to the trainee.
- The trainee should have had no previous contact with the patient.
- The trainee will NOT be able to discuss the patient with nursing staff, therapy staff or the patient's friends, carers or relatives.

For each assessment the trainee spends 60 minutes with the patient for history-taking and a clinical examination. During this time the trainee will also complete a response on the consultation form provided by the assessor.

The trainee should then spend 20 minutes with the assessing supervisor / accredited Long Case Assessors / examiner. The consultation form with the candidate's response will be read by the examiners before the beginning of this time. The examiners are aware that it is not possible to describe fully most aspects of the rehabilitation plan in the space available on the consultation form.

After reading the consultation form the examiners/assessors begin the interview by asking the trainee to summarise the clinical findings and proposed rehabilitation management in no more than two to three minutes. This discussion will focus on the trainee's analysis of the problems and the disability, and the rehabilitation management of the patient. The trainee should not spend unnecessary time during this discussion on details of the history, previous treatment or clinical examination.

After the initial presentation, the examiners should ask a number of questions to determine the trainee's knowledge and understanding of the rehabilitation issues relevant to that patient. The examiners/assessors may allow the trainee to talk without interruption, or may interrupt at any stage during this 20-minute period to ask questions.

Long Case Assessment Rating Scale

Trainees' performances are scored using seven different levels representing a broad range of skills as described on the following Rating Scale. Each level carries a numerical value to be used as a grade performance. Whole scores only are to be used.

GRADE

1. **VERY POOR PERFORMANCE**
2. **FALLS WELL SHORT OF EXPECTED STANDARD**
3. **FALLS JUST SHORT OF EXPECTED STANDARD**
4. **CONSISTENT WITH LEVEL OF TRAINING**
5. **BETTER THAN EXPECTED STANDARD**
6. **MUCH BETTER THAN EXPECTED STANDARD**
7. **EXCEPTIONAL PERFORMANCE**

The long case presentation should be evaluated by the following criteria:

(1) ***The written consultation sheet summary:*** Has the trainee identified and legibly recorded the major rehabilitation issues and goals?

(2) ***Identification of relevant problems and disabilities:*** Has the trainee identified the nature and extent of the patient's impairments and disabilities, and prioritised the important and relevant rehabilitation problems?

(3) ***Description/discussion of short-term rehabilitation goals:*** Has the trainee identified and adequately described their immediate plans for the patient?

(4) ***Description/discussion of longer term rehabilitation goals:*** Has the trainee predicted the likely long term issues and described appropriate management goals?

(5) ***Clarity and organisation:*** Has the trainee presented and discussed their findings and management in a clear, logical and organised manner?

In-Training long Case Assessments (ITLCAs)

Commencing from the second training year, 2 ITLCAs must be completed to a passing standard each term, with the last evaluation being undertaken towards the end of the term. It is important for the assessor to evaluate the trainee's performance against their level of training, the

expectation being that a third year trainee should be able to demonstrate much higher competence than a junior trainee. Trainees should try to evaluate and present a "long case" every two months during the term. The ITLCAs undertaken during the term should represent different diagnostic and management problems and where possible each assessment should be undertaken by a different Supervisor or assessor.

The Supervisor is not normally required to directly observe the trainee with the patient during the first 60 minutes however there must be at least one directly observed in-training long case assessment per year (i.e. three in total during years 2 – 4 of the training program). The Supervisor must observe the trainee without comment or interrupting the clinical interaction.

The assessor's marks must take into consideration the trainee's year of training and past clinical experience. Once the assessment has been scored the assessor must provide immediate and relevant feedback to the trainee regarding their performance, and allow time for discussion of both positive and negative areas of clinical performance.

For ITLCAs, both observed and not directly observed, marks out of 7 are to be recorded on the Long Case Assessment Form and signed by both the trainee and the assessor. These forms can be downloaded from the AFRM Website or the AFRM Advanced Training Portal. It is the responsibility of the trainee to retain these signed forms in their Training Portfolio (hard copy or electronic) and to provide them to their Supervisor at their end of term summative assessment interview when the Supervisor's Report is being completed. Between training years two and four, the AFRM Education Committee will not accept the Supervisor's Report Form if ITLCA marks are not included.

Why are the ITLCAs important?

A Rehabilitation Medicine Physician must be able to undertake all elements of the medical evaluation of a disabled person, including:

- history-taking
- clinical examination
- relevant investigations

From this information, the Consultant identifies the patient's impairments, functional issues and participation challenges, and devises a plan of rehabilitation management. This "long case" skill is integral to specialist practice, and especially in Rehabilitation Medicine, where patients often present with complex physical, cognitive and psychosocial problems.

The ITLCA encounters allow those assessing to detect strengths and weaknesses in clinical skills which can be discussed with the trainee and incorporated into their future learning objectives. Observation of one ITLCA per year is thus seen as a minimal requirement in this regard.

Observed In-Training Long Case Assessments

The following information describes the recommended manner in which the observed ITLCAs should be undertaken. It is stressed that the completion of the ITLCAs is the mutual responsibility of the trainee and Clinical Supervisor *during* the term, and that ITLCA results must be entered on the Supervisor's Report Form for the term.

A full ITLCA occupies about one and a half to two hours. While this is a substantial period of time, it is an essentail opportunity for the Clinical Supervisor to see at first hand the clinical skills of the trainee, and their ability to integrate new clinical information into a co-ordinated and relevant rehabilitation management plan. The total number of hours committed the assessment of ITLCAs during the term is only a fraction of the time that the trainee is working during the term, and should not be regarded as unreasonable or onerous in the context of the 20 – 25 hours of individual teaching time designated during each term. If each ITLCA is undertaken by a different Rehabilitation Physician the demand on the time of any one individual is small, and the overall reliability of the assessment is enhanced.

1) Case selection

Almost any in-patient on, or awaiting transfer to, a rehabilitation ward would be suitable for the ITLCA. The patient should not be known to the trainee. As the trainee will be evaluated against

their current level of training, it is appropriate to provide junior trainees with relatively straightforward cases and senior trainees with cases of greater complexity. The trainee should not be given any prior information regarding the patient. As much as possible, the trainee should be evaluated on diagnostic and management problems *not* encountered in previous ITLCAs.

2) Venue

The assessment should be undertaken in a clinic room or similar setting where the Clinical Supervisor/assessor may observe all aspects of the trainee's performance without intruding. It is important that there are no interruptions to the trainee or Clinical Supervisor: telephone calls and pagers should be suspended during the assessment. Trainees are allowed their own stethoscope and pen; all other equipment and paper should be provided.

3) Consultation form

The trainee is provided with a consultation form, prepared by the assessor, similar to that normally used in hospital practice, and containing essential details of the patient's illness/injury. The trainee is advised that they will be required to complete this form at the conclusion of their evaluation of the patient, and that their written comments form part of the assessment. The trainee is *not* to be provided with the patient's hospital file but can view medication charts.

4) Observation of performance

While the trainee is interviewing and examining the patient and reviewing the relevant investigations which may be provided, the Clinical Supervisor/assessor should be situated in the room in such a manner that they can directly and adequately observe the trainee and the patient at all times. However, they should *not* comment or interrupt, and should allow the trainee to conduct the assessment in their own time and manner. The Clinical Supervisor/assessor should record on the Long Case Assessment Form provided by the Faculty all the relevant features of the trainee's performance for later feedback.

5) Conclusion of the assessment

The assessor should halt the time with the patient after one hour. The trainee may be allowed a 5-minute break, during which the Clinical Supervisor/assessor reviews the written consultation sheet.

6) Presentation/interview

This session lasts for 20 minutes. The trainee first presents a summary of the case, lasting no more than 3 minutes. This brief synopsis is crucial to the assessment. It requires the trainee to synthesise all of the relevant clinical information into a concise summary of the patient's problems and disabilities, rehabilitation potential, and management plan. It is not necessary or appropriate to permit a trainee to speak at this stage for 8 or 10 minutes, as this effectively reduces the time available for the Clinical Supervisor/Trainer to question the trainee on relevant aspects of the case, including key features of history, examination and investigations.

It is essential that the Clinical Supervisor/Trainer has personally evaluated the patient prior to the ITLCA, and developed appropriate questions which fully explore the principal features of the case.

It is emphasised that the trainee must be assessed against their current level of training, and that performance expectations will vary across the years of Rehabilitation Medicine Training.

7) Feedback

ITLCA feedback should be given to the trainee on the day of assessment. It should be possible in most cases to decide at that time whether the trainee has attained a satisfactory level. If this decision is difficult, the Clinical Supervisor/Trainer may wish to consult with other Clinical Supervisors or Trainers.

It is usually best to first ask the trainee to describe their performance, and especially their perceived strengths and weaknesses during the assessment. Such personal observations may well correlate with your own.

You should then provide feedback based on your direct observation of history taking and examination, and in particular detailing areas where the trainee's methods or approach differed to your expectations. Remember that there are various approaches to clinical assessment; the trainee should not be criticised unless they were inaccurate, incomplete or disorganised in their performance. It is vital to point out where such errors resulted in wrong or inadequate conclusions regarding diagnosis and/or management. Keep in mind that the trainee may have been anxious during your direct observation, but that this is not in itself an excuse for significant inaccuracy or disorganisation.

Invite the trainee to discuss your observations. Even though you observed the performance yourself, there may be reasons/explanations for various facets of their performance which you questioned. Also remember to praise areas of performance which were accurate or skilful.

After this discussion, and when you have decided the trainee's score for the assessment, enter final comments on the Long Case Assessment Form before giving the form to the trainee. Ensure that you print and sign your name, and indicate the type of case examined.

8) Who should undertake ITLCAs?

ITLCAs can be assessed by the current Clinical Supervisor or another Fellow of the Australasian Faculty of Rehabilitation Medicine. The assessors should familiarise themselves with all the above information, and may gain valuable experience in this type of assessment by "observing" with another trained and accredited Long Case Assessor Clinical, or by attending calibration workshops organised by the Faculty.

Formal Long Case Assessments (FLCAs)

Although the Long Case Examination component of the Fellowship Clinical Examinations has now been phased out, the Long Case Assessment remains an important and integral part of the Rehabilitation Medicine Advanced Training Program's assessment processes.

Since 2003, in place of the Long Case Examination component of the Fellowship Examinations, and in addition to the 12 compulsory In-Training Long Case Assessments, all trainees are required to complete two satisfactory long case assessments under examination conditions (Formal Long Case Assessments) during their third or fourth year of Advanced Training.

These summative assessments are to be conducted and marked in the same manner and format as In-Training Long Case Assessments although a separate FLCA form needs to be completed and returned to Faculty Office for review. **The assessors do not advise the trainees of their results and no feedback if provided.** The Faculty Office advises the trainees of their results. The FLCAs must be assessed by two Fellows of the Faculty, one of who must be a currently accredited AFRM Long Case Assessor. The other assessor may be the trainee's current Supervisor, Trainer or other nominated Faculty Fellow.
The assessors are not required to directly observe the trainee during the 60 minutes spent with the patient for history-taking and clinical examination.

It is the responsibility of each trainee to contact a suitable assessor and liaise with their Clinical Supervisor/Trainer to organise a convenient time and venue for the assessments to take place. A list of the currently accredited AFRM Long Case Assessors is published on the AFRM website or can be obtained from the Branch Training Coordinator or from the Faculty Office. The two assessments may be completed at different times with different assessors or together if necessary. There will be no restriction as to where or when the assessments are held.

The two FLCAs must be completed to a satisfactory standard (i.e. equal to or greater than 4/7) in order to fulfil this component of the Advanced Training Program although the assessments may be attempted on any number of occasions within the third or fourth year of Advanced Training.

ROLES AND RESPONSIBILITIES OF CLINICAL SUPERVISORS

The supervisor for each six-month term of training will normally be one of the Rehabilitation Physicians to whom the trainee is responsible for his/her work, and they should have a close working relationship with the trainee. As the emphasis in the training program is on education and direct experience, this places a significant responsibility on the supervisor and underlines the importance of the role.

The primary role of the supervisor during the term will be to provide **formative assessment** (feedback and discussion on performance). Such assessment assists the trainee to evaluate their knowledge and skills, and to identify their individual strengths and weaknesses in a setting that is non-judgemental and non-threatening. Regular evaluation (based on the supervisor's report form and by reviewing the trainee's Learning Needs Analysis as well as by progressively completing In-Training Long Case Assessments) orientates the trainee to the expectations of the Faculty in respect of competency standards. Regular evaluation will also alert the supervisor to the trainee's ongoing needs, and will allow modification of training to the trainee's learning objectives. Positive feedback can strongly motivate trainees to further learning. Appropriate feedback in areas of deficiency should also motivate, and may stimulate the supervisor and trainee to review together the learning objectives set for the term. (Refer to Attachment 2, Pages 34 and 38, Self Checklists for *Assessing the Effectiveness of a Learning Plan* and *Giving Feedback to Learners*.)

Regular meetings with the trainee, observation of history taking and physical examination, discussion of the interpretation of clinical findings, clinical evaluation of investigative procedures and discussion of rehabilitation planning and management are all appropriate clinical tools for formative assessment.

The supervisor also has the responsibility to provide **summative assessment** (formal determination of competence) to the Faculty Education Committee at the end of the term, by completing a Supervisor's Report Form. This report is the Faculty's most important means of evaluating the trainee's performance.

The supervisor and trainee meet at the beginning of the term to plan a program of training for the term that is:

(i) consistent with the training requirements;
(ii) appropriate for the stage of training; and
(iii) appropriate to the trainees needs.

The supervisor should clearly explain the nature of the workload in that training post and the full extent of the trainee's clinical and administrative responsibilities.

There should be clear understanding of the lines of responsibility and communication and of the supervisor's expectations with regard to the trainee's involvement in ward rounds, team meetings, clinics, family interviews and other activities.

The supervisor must clearly indicate his availability and that of other specialists to whom the trainee is responsible.

The supervisor should indicate if other Fellows or specialists are available as trainers.

The trainee should be advised of available library and educational resources.

During the term, adequate RMO support should be available, so that the trainee is not required to undertake a significant volume of routine clinical clerking and is thus available for direct participation in rehabilitation management and decision-making.

The supervisor should enable the trainee to attend all scheduled training lectures, courses and workshops, and to attend relevant hospital and local in-service activities.

It is vital that clinical teaching take place, as much as possible, during routine clinical activities such as ward rounds and clinics. In addition, the supervisor should ensure that the trainee receives at least 60 minutes per week of face-to-face discussion regarding clinical practice, either with the supervisor or other specialist staff. Ideally, the trainee should review a specific clinical topic, usually based on the Bi-National Training Program timetable or perhaps related to recent

clinical experience. **The trainee should not expect the supervisor to provide didactic teaching in this situation.**

Where relevant, the supervisor and trainee should discuss prospective clinical research and/or quality management projects, identifying suitable projects and planning the implementation of such activities within the framework of other clinical responsibilities.

The trainee should also review the Supervisor's Report Form which is to be completed at the end of the term. This document is used to assess the trainee's progress. The trainee should be aware that assessment includes humanistic qualities as well as other aspects of professional behaviour.

Plans should be made and dates set for regular formal meetings with the supervisor during the term, at least every 2 months, to ensure that the learning objectives of the term are being met. This is particularly important if there are additional requirements such as courses and projects.

The trainee should be given opportunity and encouragement to provide feedback to the supervisor about the proposed training program, previous experience and expectations of further training.

ROLES AND RESPONSIBILITIES OF CLINICAL TRAINERS

While the Clinical Supervisor will have the primary responsibility for clinical supervision during the term, it is likely that a number of Faculty Fellows and other medical and allied health specialists will also be involved in teaching the trainee. Such specialists are regarded as clinical trainers. Given the multi-faceted nature of rehabilitation, exposure to teaching from specialists in other disciplines (such as neurology, orthopaedics, rheumatology etc) is highly desirable.

The Clinical Supervisor may well have organised such teaching. If not, they should at least be aware of and attempt to coordinate the contributions of these other trainers. The Clinical Supervisor should regularly liaise with the other trainers to ensure that teaching is relevant to both the objectives of the training program and to the trainee's personal learning objectives for the term.

Trainers should, as much as possible, be familiar with the requirements of the Rehabilitation Medicine Training Requirements Handbook (2010), the Rehabilitation Medicine Curriculum and the RACP's Professional Qualities Curriculum. They should attempt to structure their teaching on specific topic areas or clinical problems.

The Clinical Supervisor should seek regular feedback from the other trainers with regard to their teaching, and the attitude and progress of the trainee. Such feedback is very relevant to both formative and summative evaluation of the trainee during the term.

THE SUPERVISOR'S REPORT

Formative and Summative Assessment

It is the responsibility of the trainee to ensure that the supervisor's report is submitted to the Faculty office promptly on completion of the term. All reports must include at least two satisfactorily completed in-training long case assessment marks for that term.

Failure to submit a report within 3 months of the end of the term may result in non-accreditation of the term. When a report has not been received at Faculty Office within the 3-month period the Faculty Education Committee can approach the Supervisor directly to obtain a report.

In accepting the responsibility to be a supervisor of a trainee, the supervisor also accepts responsibility to provide the trainee with a Supervisor's Report at the end of every six-month training term. A trainee has a right to expect his supervisor to complete the report but no right to expect that the report be satisfactory.

Satisfactory Supervisor's Report

A satisfactory Supervisor's Report is defined as one in which a candidate has scored *'3'* or more in each evaluation section of the report. This signifies that the candidate has met the expected standards of training during the period of the report. Expectations must be congruent with the level of training and past clinical experience.

Unsatisfactory Supervisor's Report

An unsatisfactory Supervisor's Report is one in which a coding score of '2' or '1' appears in any section of the report.

A score of '2' or '1' in any evaluation section of the report indicates an area of weakness that must be addressed in the trainee's program. The importance of improving the strength of the trainee in this area is emphasised. It is expected that once a weakness has been identified by a score of '2' or '1' that progress to a satisfactory score in that section should be achieved within the subsequent 6 months.

If the candidate fails to progress to a satisfactory standard (i.e. the score remains at '2' or '1' in that section on subsequent reports) the Faculty Education Committee will consider the reports as evidence of continuing unsatisfactory performance.

If coding scores of '2' or '1' appear in other sections of subsequent reports, even though there has been improvement in the original section that was unsatisfactory, the Faculty Education Committee will consider such reports as evidence of continuing unsatisfactory performance.

For the initial unsatisfactory report, planned remedial action may be recommended by the Teaching and Learning Subcommittee of the Faculty Education Committee following discussion with the trainee and Supervisor.

Independent Review of Training

For subsequent unsatisfactory reports (i.e. those including a score of '2' or '1' in second and subsequent reports), the Faculty Education Committee will require a formal Independent Review of Training (IRT) Interview. This will be convened at a venue nominated by the Faculty Education Committee. The interview panel will comprise one or more members of the Faculty Education Committee and, in most cases, the relevant Branch Training Coordinator. The purpose of the interview is to investigate the nature of the trainee's performance problem/s, and to advise the Faculty Education Committee regarding appropriate remedial action.

Following this interview, the Faculty Education Committee will decide whether or not to approve part or whole of the period of training covered by the report. If not approved, the trainee may require an additional period of training. The Faculty Education Committee may recommend a specific remedial program. Full compliance with this program is mandatory for continuing registration as a Faculty Trainee.

The Faculty Education Committee will review the trainee's progress when the next Supervisor's Report is submitted. If unsatisfactory progress continues, removal from the Faculty's Training Program may be required.

EVIDENCE OF COMPLETION OF TRAINING TERMS

The Faculty Education Committee regards the Supervisor's Report Form as an important component of the Advanced Training Program. In addition to identifying areas of weakness of the trainee which require remedial action, the report provides evidence of satisfactory/unsatisfactory training for the period covered by the report. It is a requirement that the trainee completes four years of accredited (certified) Advanced Training.

Following a period of 12 months or more of training which has not been certified as satisfactorily completed, the Education Committee reserves the right to ask the trainee to show cause why their name should not be removed from the Faculty Register of Trainees. (Commencing from 1 January 2013 trainees whose training has been involuntarily discontinued because of failure to progress, are not eligible to re-enrol in any College training program. Please refer to RACP *Progression through Training Policy*.)

PRINCIPLES OF TEACHING AND LEARNING

Adult Learning

To provide high quality rehabilitation care, trainees need to become competent, self-directed, lifelong learners. During training, they should develop necessary skills in self-assessment, information management and problem solving. The Clinical Supervisor or other trainer has an important collaborative role in this process.

Such a collaborative approach utilises key principles of adult learning: namely, that adults

- learn better by active participation in goal-oriented teaching
- require a supportive learning environment emphasising achievement and progress
- have differing educational and personal backgrounds, learning needs and styles
- are motivated by a variety of different factors
- share a valuable common resource: experience

A collaborative learning relationship that recognises the valuable contribution the trainee can make to their own and other's learning:

- requires the trainee to assess and identify their personal learning needs.
- requires the trainee and Clinical Supervisor/Trainer to set a learning agenda (e.g. in the form of a learning contract or approved Learning Needs Analysis) reflecting their individual and shared learning goals.

Learning Styles

Many schemes have been proposed for identifying and understanding learning styles. No one scheme can fully describe the complexities of these processes.

The Myers-Briggs approach utilises 4 psychological continuums to describe personal attributes relevant to learning. Most people are not at the extremes of these scales, but tend to incline toward one end or the other.

- Extroversion/introversion

  Extroverts learn well with others on the outer world of objects and action, prefer to be active, and may use a trial and error approach to learning.
  Introverts focus on the inner world of ideas and concepts, prefer reflection to action, and often study alone.

- Sensing/intuition

  Sensing types perceive immediate, real and practical facts of experience. They are observant, and skilled at remembering and using factual information.
  Intuitive types focus more on possibilities, relationships, and the potential meanings of experience. They may be creative, imaginative and good at problem solving and generating new ideas.

- Thinking/feeling

  Thinking types make judgements and decisions objectively and impersonally.
  Feeling types make more subjective and personal judgements.

- Judgement/perception

  Judging types function in decisive, planned and orderly ways, aiming to control and regulate events.
  Perceptive types prefer to adapt to life by being spontaneous and flexible.

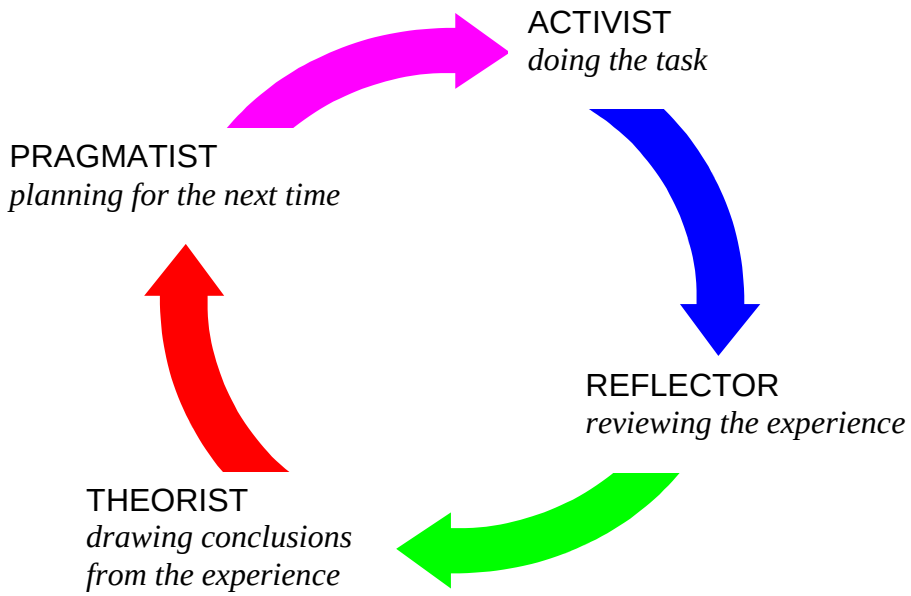
Another approach to assessing learning styles relates to the way trainees approach their work and handle problems. Four broad groups were identified by Honey and Mumford:

Activists are enthusiastic and open-minded, and throw themselves into new experiences. They will "try anything once" before moving on to another task. They may become frustrated by sustained activity and long-term consolidation.

Reflectives like to think about things first. They will collect all the data they might need before making a decision. They tend to be cautious, and may have difficulty making clear-cut decisions.

Theorists think things through in a logical and careful manner. They tend to be perfectionists, and prefer information to be clear and objective. They analyse and synthesise, and prefer to work with maximum certainty.

Pragmatists are keen to try things out and to see how they work in practice. They try to make things happen, and can become frustrated if they can't **do** things. They are usually practical and down to earth people who enjoy problem solving and decision-making.



If one considers the task cycle of the learning experience, it can be appreciated that each style is relevant. It is easy, however, to become overly focused on one aspect of the cycle. Different types of individuals are likely to get "stuck" at different places in a learning cycle. If a trainee is having difficulty with their workload, or in completing work tasks, consider the diagram above, and be prepared to discuss your mutual perceptions of these problems.

Trainees should be encouraged to reflect on their past positive and negative learning experiences and their own personality, and to shape their learning goals and methods on this information.

As a Clinical Supervisor, it is equally important to reflect on your own preferred intellectual and leaning styles, as these will directly influence your interaction with trainees, many of who will differ in their own styles. Conflict in learning styles between a Clinical Supervisor/Trainer and trainee can frustrate and diminish the mutual learning experience, and should be recognised and discussed as soon as possible. While different styles can enhance and enrich a group learning situation, diametrically opposed styles between a Clinical Supervisor and trainee may significantly interfere with instructional rapport and communication.

The Role Model in Clinical Training

Clinicians should strive to be good role models for their patients and staff. In the same manner, the Clinical Supervisor should be a positive role model for the trainee. 'Teaching by example' will inevitably occur, whether the teacher appreciates this or not! The example of the Clinical Supervisor will in many cases have greater impact on the trainee than what the trainee is told to do. This is both a conscious and unconscious process on both sides.

No individual clinician/teacher is perfect. What often occurs is that a trainee will see desirable characteristics which they will try to emulate. The Clinical Supervisor should be aware of this, and model those attributes and capabilities as much as possible.

The Clinical Supervisor should also be aware that negative attributes (e.g. tardiness, poor communication, low empathy) may also be perceived by the trainee as acceptable behaviours and in come cases reflected in the trainee's performance. The importance of appropriate and unambiguous professional behaviour by the Clinical Supervisor cannot be overestimated.

Role modelling importantly involves not only cognitive skills but also professional behaviours and attributes. These are often difficult to describe and define, and are often best taught by example. The essential professional behaviours and attitudes for Rehabilitation Medicine are described in the RACP's Professional Qualities Curriculum.

The example of the Clinical Supervisor can exert a powerful influence on the perception of the specialty of Rehabilitation Medicine by patients, families, staff, and by junior medical officers who may be considering future specialty training. The behaviour and attitudes of Clinical Supervisors directly influences the "popularity" of any individual training term. Positive role models can strongly influence a trainee's life and future career.

For all of these reasons, role modelling should be an intentional activity of the Clinical Supervisor, who should make deliberate and explicit attempts to demonstrate appropriate knowledge, skills and personal behaviours, and to articulate the importance and value of these domains.

In evaluating your impact and potential as a role model, remember the following:

- Be aware of your personality and your approaches to patient care and teaching. Try to be aware of the overt and subtle messages you transmit to those around you. Seek feedback from people who are close to you, who you feel can be objective, and whose opinions you value.

- Recall your own most influential role models. Which of their attributes had the most powerful influence on you, and why?

- Reflect on what you regard as your own best qualities. Can you do more to articulate and demonstrate these attributes?

- Reflect on the positive attributes and qualities of your trainee, and how he/she is a positive role model to those around them. Consider the importance of encouraging and assisting the development of their individual personality and professional style.

- Maximise the exposure of your trainee to you in as many clinical and non-clinical settings as possible, interacting with patients, families, colleagues, staff and friends in various situations.

- Be prepared to share with your trainee your thoughts and feelings about your career, and how you cope with the demands of professional life. The value of this type of information is very important to the shaping of career attitudes and adaptive professional behaviours.

EFFECTIVE CLINICAL SUPERVISION

Roles and Models of Clinical Supervision

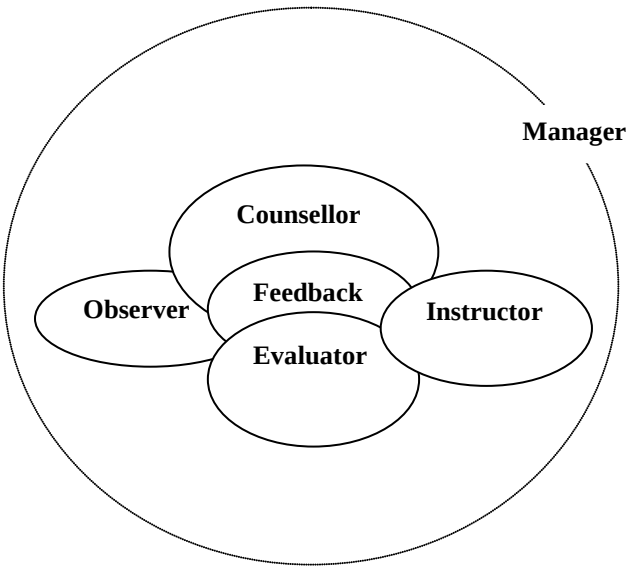
Clinical supervision plays a crucial role in assisting health professionals to integrate theory into practice and to prepare for the reality of their future professional roles. Trainees bring to their training terms a wealth of explicit knowledge but need to develop the tacit knowledge, and the personal and practical skills, of the experienced clinician.

Six supervisory roles are described which provide a useful framework to examine clinical educator activity:

- manager
- counsellor
- instructor
- observer
- provider of feedback

- evaluator

These are not the only roles described in supervision practice, but they provide a logical framework. Roles will often overlap and may be fluid over time.



The ***manager*** role is one of coordination and planning. It involves the smooth running of the term and, importantly, establishes the setting that facilitates all the other roles. The four components of this role are planning, organising, liaising and motivating.

Planning, *organising and liaising* commence with coordination and communication between the Faculty, hospital and rehabilitation staff, and other stakeholders. Liaison commences well ahead of the term.

By *organisation and planning,* the trainee is facilitated to set learning objectives for the term with reference to Faculty requirements and to detail any specific projects or activities. An induction or orientation interview should be held to ensure that the trainee understands their roles and responsibilities, establishes good relationships with key staff, and undertakes other initiatives such as learning contracts or completion of the Learning Needs Analysis on-line tool. Individual time should be spent with the new Clinical Supervisor/Trainers to encourage and support this preparation. Physical resources, such as workspace and computer access, should be assigned, and a timetable of activities provided including ward rounds, meetings and teaching sessions.

The role of *motivator and enthusiast* is very important in encouraging the trainee to develop confidence in their clinical skills. The trainee should be encouraged to attend all Faculty training sessions and to develop autonomy in their learning. During initial orientation, previous clinical experience should guide the Clinical Supervisor and trainee in setting relevant and achievable learning objectives. This is very important in maintaining motivation and enthusiasm.

The ***counsellor*** role aims to develop positive attitudes and cooperation, clarify behaviours and resolve conflict. The role is central as it deals with the affective and interpersonal domains of the training experience. Trainees and Clinical Supervisors need to establish positive relationships, to promote opportunities for co-operative planning, and tactics to deal with difficult or stressful situations. Valuable information can be gained by exploring the trainee's past experiences of clinical supervision.

Not every trainee and Clinical Supervisor will be compatible. Strategies may need to be implemented to ensure that a productive working relationship is established, providing support to both Clinical Supervisor and trainee. As a manager, this role can require subtlety, necessitating an awareness of the principles and skills of counselling, and at the same time promoting the trainee's self esteem.

The ***instructor*** aims to communicate information on ideas and practices verbally or by example, to facilitate constructive analysis of trainee performance and ideas, use problem-solving skills to develop self-reliance, and to plan further ways to enhance learning.

Presenting or modelling a skill to trainees usually requires a directive manner, although the use of nondirective methods, such as questioning and guided discussion, can be used to develop problem-solving skills and self-awareness.

The ***observer*** role facilitates the provision of feedback on the strengths and weaknesses of trainees, and the further development of knowledge and skills. Both Clinical Supervisors and trainees need to understand the purpose of observation, to set the parameters of what is to be observed, and to agree upon how this information will be used and recorded. During observation, the Clinical Supervisor aims to build a clear record of what was observed and to conduct a preliminary analysis before assigning priorities for discussion in feedback sessions. Discussion of these processes should be undertaken in the induction interview at the beginning of the term.

In providing *feedback*, the Clinical Supervisor informs the trainee about their performance and progress. The aim of feedback is to assist recall and provide analysis and interpretation of trainee performance, and by doing so to indicate strengths and weaknesses. This provides the basis on which to promote further learning, goal setting and behaviour change in a collaborative and positive approach between trainee and Clinical Supervisor.

The ***evaluator*** is concerned with making judgements about the overall progress of the trainee, assessed with regard to the agreed objectives of Advanced Training and the specific training term. This is done as a structured formative evaluation occurring every two months, and informally during the term. Summative evaluation is undertaken at the final assessment at the end of the training term, by completion of the Advanced Training Supervisor's Report. Trainees are encouraged to self-evaluate at each of the formative and summative evaluations, providing the opportunity for collaborative reflection and goal setting.

Styles of Supervision

Supervisors each have a style or styles that they use in carrying out their roles. The three orientations of these have been described as

- directive
- collaborative
- non-directive

Most supervisors would use all of these styles at some point in their supervision, depending upon the learning task, circumstances and the maturity of the student.

The following discussion outlines the pertinent points of each style and provides examples of how each can be utilised in the clinical setting.

Directive

This approach includes the major behaviours of:

- Clarifying
- Presenting
- Demonstrating
- Directing
- Standardising
- Reinforcing

A directive approach does not mean that the supervisor assumes an autocratic role. It presumes that in some situations the supervisor will know more than the student, and that an effective way of improving instruction is to show the student in a tangible way how a certain standard can be achieved.

Examples of this include the imparting of mandatory information such as clinical practice guidelines. Set objectives, evaluations and assignments would also fall into this category. A directive approach might suit more junior trainees, or the learning of potentially complex or high-risk skills.

Collaborative

This approach includes the major behaviours of:

- Listening
- Presenting
- Problem solving
- Negotiating

The end result of this approach is mutual agreement upon process between trainee and Supervisor, using friendly negotiation and excluding neither point of view. This presupposes that each individual's ideas may not be as effective as mutual ideas. Therefore, agreement and acceptance for change or compromise is desirable.

Examples of this include learning contracts, tutorials, projects, caseloads and levels of supervision. Time must be allowed for the trainee to solve problems, discuss initiatives, review their learning objectives and determine future priorities. This approach is most appropriate for middle to senior trainees.

Non-Directive

This approach includes the major behaviours of:

- Listening
- Encouraging
- Clarifying
- Presenting
- Problem solving.

The major premise of this approach is that trainees are capable of analysis and problem solving, and that taking responsibility for this makes learning more meaningful. The role of the Clinical Supervisor then becomes one of a facilitator, using the above behaviours to direct the trainee towards self-discovery without imposing a formal structure.

Examples of this include allowing the trainee to develop their own learning experiences, projects, tutorials and learning contracts. The Clinical Supervisor is used as a sounding board, for clarification and problem solving, presenting suggestions and resource material only as requested. This could be an approach with a final year trainee who was able to demonstrate a high level of independence and confidence. There would need to be elements of the directive and collaborative approaches to facilitate the trainee to this point, and these may still be appropriate at times within an overall non-directive approach.

The training term experiences provide trainees with important opportunities to practise their professional skills in a real situation and to integrate theory to the level required for professional competence. These experiences also promote the professional socialisation of emerging clinicians. For supervisors, the provision of positive learning experiences and the modelling of relevant professional behaviours is a potent responsibility to be undertaken with thought and care.

To be an effective clinical educator, it is necessary to develop self-knowledge about values, beliefs and approaches to learning. It is essential for supervisors to understand the various roles encompassed by them as clinical educators and the supervisory styles they utilise. Models of supervision provide valuable guidance for both experienced and new supervisors in the provision of a framework for practice.

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PERFORMANCE FEEDBACK

What Is Performance Feedback?

Feedback is an important and well-recognised principle in many mechanical and biological systems. It is usually regarded as vital for smooth and optimal functioning.

In human systems, performance feedback involves the identification of specific “strengths” and “weaknesses”. The former are to be encouraged and nurtured. The latter are regarded as areas of potential growth and development.

Why Is Performance Feedback Necessary?

In the past, performance feedback in medical training has in general been undertaken very poorly. Feedback was often vague, inadequate and untimely. Effective feedback must be specific, and given at an appropriate time to encourage and permit behavioural change.

Supervisors and Trainers should recognise that trainees do *not* instinctively know if their performance in any area is satisfactory! In many surveys of student expectations, students rate constructive performance feedback very highly. Supervisors, however, often rate their ability to give feedback more highly than do their students!

Lack of feedback can have deleterious effects on both good and bad clinical practice. Without feedback, errors in performance can become entrenched “bad habits”. Without feedback, students may discontinue good practices or fail to fully develop intuitive skills, because they do not recognise and value their own strengths.

It should be stressed that there is no such thing as a “neutral” interaction between a teacher and student. Students keen for feedback may perceive it in the form of verbal statements or body language, even when such feedback is unintentional. Where little formal feedback is given, there is the possibility that "neutral" feedback may be misperceived as "negative" feedback.

Why Is Performance Feedback Often Done Poorly?

An important reason is that many Clinical Supervisors/Trainers had little personal experience of effective feedback during their own training, and possibly experienced negative or destructive feedback. Many trainers did not encounter good role models, and were not exposed to appropriate attitudes and methods. Later, busy clinical practice did not allow sufficient time to develop these skills.

Many supervisors are uneasy about the potential impact of feedback. Some believe that positive feedback may threaten the necessary professional distance in their relationship with the trainee, or perhaps discourage the trainee from further effort or learning. At the same time, negative feedback is seen as difficult, possibly hurtful to the trainee, and perhaps damaging to the personal relationship with the Supervisor.

For such reasons, it is not surprising that the feedback provided is often vague and indirect. A trainee receiving such feedback may not feel satisfied, but is unlikely to pursue the matter for fear

of eliciting negative feedback. Eventually, both the Supervisor and trainee form a relationship where feedback is superficial and where real issues are not addressed.

There is no doubt that, when offering feedback, a supervisor is taking a risk, but there are ways to manage this risk, and to use the feedback experience to deepen the relationship with the trainee, and to further develop supervision skills. A worthy goal is a relationship with the trainee in which he/she invites comment on their performance on a regular basis.

Improving the Quality of Performance Feedback

Here are 10 tips to improve your own clinical supervision:

1. At the outset, determine the trainee's past experience of feedback, both positive and negative, and their readiness to enter a relationship with you in this regard. Talk through past negative experiences, and attempt over time to establish a "climate of trust" in which their professional performance can be observed, evaluated and discussed. As a supervisor, aim to be *competent and credible, caring and concerned*.
2. Provide feedback in regular, private, structured sessions, as often as necessary to develop your relationship and to address necessary issues. At the same time, provide brief and relevant concurrent feedback in instructional encounters in clinics and ward rounds, but ensure that this feedback is focused on professional behaviour and clinical skills, and that sensitive feedback is not given in front of patients or staff.
3. *Always ensure that feedback is relevant to the objectives of training, and to the trainee's individual training goals; and that your feedback is based as much as possible on your own direct observations.* Where necessary, refer to the Faculty Training Manual and the written Clinical Supervisors Report, which details all the required areas of evaluation. In our discipline, the observations of other health professionals are invaluable in global evaluation, but nothing can replace specific comments based on the supervisor's repeated, accurate and direct observations of the trainee's work.
4. Before providing feedback, invite the trainees to evaluate their own performance. Then introduce your general observations, and explore with them the assumptions or conclusions that you have made. Make sure that you have all the facts that you need, and that you've "got it right" before proceeding. Avoid premature feedback! There may be important issues of which you are unaware!
5. As far as possible, and especially in structured sessions, give positive feedback *before* negative feedback. There are always positive aspects of performance. Negative feedback is often more palatable when it is preceded by a genuine and positive *appraisal* of satisfactory performance, which serves to identify the areas of difficulty in a broader context.
6. Make feedback *specific and non-judgemental.* Both the positive and negative attributes and actions of the trainee should be evaluated with regard to their effects and outcomes. Emphasising the *outcome* of a behaviour or action is often more instructive than describing the behaviour or action in isolation. Avoid negative descriptors such as *lazy* or *incompetent*, and similarly avoid excessively positive descriptors such as *brilliant* or *fantastic*. Such comments tend to be superficial and meaningless. It is preferable to ground your comments on specific examples of actions or behaviours that were significant with regard to either actual or potential positive or negative outcomes. Relevant goals in Rehabilitation Medicine include the treatment and well being of the patient, the trainee's relationships with families and the rehabilitation team, and communication with other agencies.
7. Feedback is invariably "subjective". Even when you have directly observed the trainee, your judgement will of course be based on your own experience, habits and values. This does not necessarily weaken your position. You are after all, an experienced clinician, and your opinion of the trainee should be accurate and relevant. But acknowledge that it is *your* viewpoint. Use specific comments such as "I saw that you…" or "I believe that you…". Admit that this is your point of view, and that your point of view is important, but not necessarily the final word on the matter! Encourage the trainee to hear your feedback. Encourage discussion and (as much as possible) agreement on the important aspects of their performance.

8. *Avoid feedback overload!* It is possible to overload the trainee with feedback, whether positive or negative. You should allow time for the trainee to absorb your comments, to self-reflect, and discuss issues further. Particularly with negative feedback, plan what you are going to say, and focus only on the most important issue/s. Go slowly, and observe the trainee's responses. Trainees vary in their *receptivity* to feedback. Excessive feedback may cause the trainee to become defensive, and to hide their difficulties. During any single encounter, monitor closely for their understanding of your feedback, and their emotional comfort in discussing any issues. If necessary, keep such interviews reasonably short.

9. *If there is a problem, then you must both have a plan!* If your observations of the trainee reveal significant problem areas, then it is vital to formulate a plan by which you will both address and review these issues. The plan should specify the problem areas, the agreed remedial action/s, and the mechanism/date of subsequent review. Such a plan should be written on or appended to a copy of the Advanced Training Supervisor's Report. Such an approach may be necessary where problems are of a serious nature, and especially where the trainee is in danger of failing the overall term evaluation. Whatever the difficulties, continue to demonstrate your concern and your support.

10. *Develop an awareness of your own strengths and weaknesses as a supervisor.* It is important to know your own supervisory style, and to perceive how you present to those around you, particularly junior staff. Seek feedback from your trainee if you are uncertain. If you have developed a good relationship, they may provide you with interesting and informative feedback! Remember that the supervisor-trainee dynamic is very much a two-way affair, and that the willingness and readiness of the trainee to work with you will depend on your own attitudes and actions in clinical practice and in supervisory sessions. Acknowledge to yourself and to your trainee that clinical supervision is a skill that you are developing. Be prepared to grow and change. Your trainees will welcome your honesty.

FORMATIVE EVALUATION

The Faculty Education Committee regards formative evaluation and the process of formative interviews as a key activity of effective clinical supervision. The interviews at two and four months of the term provide the Clinical Supervisor with the opportunity to explore and understand the trainee's progress in training, to identify the trainee's strengths and weaknesses, and to identify problems in the training term. Linking some of these interviews to landmark events in the term, such as an ITLCA, can be especially helpful.

The Faculty and the Royal Australasian College of Physicians offer training sessions in skills pertinent to this activity each year. Clinical Supervisors are expected to attend these workshops as often as possible.

Where formative evaluation during the term identifies problems or difficulties about which the Clinical Supervisor is uncertain, or for which they need advice, they are encouraged to contact either the local Branch Training Co-ordinator, or the Chair of the Faculty Education Committee. They can provide confidential advice based on their extensive past experience, and their knowledge of the Education Committee's expectations and requirements.

The manner in which formative assessment and interview is undertaken is critical to its success. The information below gives a general outline of the process. You are also advised to read *Performance Feedback,* in the previous pages.

The Formative Interview

At the beginning of the training term, the trainee should clearly understand that formative interviews will be undertaken, and will be based on the Supervisor's Report Form.
Prior to the formative interview, the trainee should be asked to complete their own copy of the Supervisor's Report Form. One can be downloaded from the Rehabilitation Physician Education section of the Faculty website.

Encourage the trainee to reflect on their performance so far during the term, and to give a single score against each of the items on the Supervisor's Report Form. This is an important step in the process, as it requires the trainee to assess their performance in multiple domains, and to commit to a specific level of performance. It should be emphasised to the trainee that the 'score' is a

starting point for discussion, and not the final word! It is not uncommon for trainees to evaluate their performance at too low a level, and in many cases they may be pleased to hear that their Clinical Supervisor rates their performance more highly! Unfortunately, the reverse may also occur.

The trainee's completed copy of the Supervisor's Report Form should be provided to you two or three days prior to the interview. Read the report and consider each response carefully. Pay particular attention to items 1 and 5, which describe professional behaviours and attitudes. This area is one where many trainees may have difficulty, especially with their professional role and interdisciplinary management.

Under patient care, consider the knowledge and clinical skills the trainee has demonstrated in clinical encounters with you, in their teaching of other staff, and in your own teaching sessions. Remember that their level of knowledge and skill is to be evaluated at a standard *relative to their level of training*. Your expectations of a third or fourth year trainee will be very different from that of a junior trainee.

Areas such as development of a rehabilitation plan, patient management, and communication skills can be evaluated in part by examination of clinical records and other written patient management information (e.g. team meeting reports).

The technique of the "360° interview" is relevant to trainee evaluation. This involves your discussion with key staff members who observe and interact with the trainee in different settings. This includes other Consultants and Registrars, nurses and allied health professionals, and junior medical staff. All will observe different facets of the trainee's performance, and can provide specific feedback from multiple sources, on the trainee's attitudes and skills from different perspectives. This is particularly relevant for the problem trainee, whose difficulties may be specific to certain clinical or professional domains. The trainee should be made aware at the beginning of the term that such interviews may be undertaken.

Assessment of areas described in Section C of the Supervisor's Report Form will depend on the trainee's particular activities during that term. Do not assume that these areas are covered by their completion of the relevant external training modules. It is important to evaluate whether the trainee is participating adequately and satisfactorily in routine service activities, team co-ordination (Item 16), Continuing Medical Education activities such as journal clubs and other teaching (Item 17), and general quality management activities (Item 19). The trainee's limited but definite participation in these activities should be expected at all levels of training and in every term.

The actual formative interview should be scheduled at a mutually convenient time and place for both the Clinical Supervisor and trainee. Allow about 45-60 minutes for adequate review and discussion of all areas. The interview should not be conducted "on the run" or where distractions or interruptions may occur. If possible, choose a neutral venue away from telephones and staff. In summer, try a shady garden seat and a tasty sandwich!

Begin by allowing the trainee to describe their general impression of the term to date, and don't be overly concerned initially with the Supervisor's Report Form or issues raised in it. Ask the trainee to disclose "the good and the bad (and the ugly)" about their experience. Acknowledge any difficulties they may have experienced. Try to understand the perspective of a trainee doctor who has come to a new (and possibly very different) hospital and training term, and who carries all of the usual anxieties and concerns about coping with work/study, and making a good impression.

Remember that you yourself were in exactly this situation in the past. When appropriate, move on to the specifics of the Supervisor's Report Form, explaining (if you have not done so already) that this assists you *both* in focussing on the relevant aspects of the trainee's performance.
There are a number of approaches to this review. You may wish to begin at Item 1, and to briefly discuss each item as you move through the report. This may be very time-consuming, and is often unnecessary.

Another approach is to review each of the three domains of the report. That is: attitudes and professional behaviours, patient care, and the items clustered in Section C. In each domain, you may choose to accept the trainee's satisfactory self-evaluation on any specific item, although you should at least state your agreement so the trainee can see that you acknowledge their performance and their evaluation. It is always worth recognising and discussing self-evaluations of

4 and **5**, as the trainee is clearly indicating their belief that they have above-average skills in these areas. If so, ask them to describe those, and give them the opportunity to explain and expand on this area. It is very important to give due recognition to areas of above-average knowledge and skill, and to encourage the trainee to continue to develop such skills.

Another approach is to focus initially on areas or scores of 4 or 5, proceeding as above to explore and define these skills. This certainly starts the interview on a positive note, and may assist later on if there needs to be discussion of problem areas in the report.

A note of caution: Do not feel that it is necessary to bring the trainee "down to earth" if you disagree with their evaluation of 4 or 5 on any item. It is more important to explore the reasons for their perceptions, and to understand the basis of their self-assessment. Remember that the formative process occurs in confidence between you, and it is often just as difficult for a trainee to describe above-average performance as it is to admit areas of difficulty.

What matters more, provided that their item performance is in fact satisfactory, is that you both (over the length of the term) come to an understanding of each other's beliefs and perceptions with regard to the trainee's performance and your own fairness in rating it. Remember that, as a Clinical Supervisor, you can't see everything. You may decide to take a trainee's above-average self-evaluation *on trust*, provided that you have no reason to doubt it. This is preferable to making potentially negative (or at least neutral) statements about areas where a trainee may feel that they are making above-average progress.

Any item that the trainee evaluates at 1 or 2 must be discussed in detail, whether you agree with this low assessment or not. The trainee is clearly indicating an area of difficulty, and this warrants full exploration. Reassure the trainee that the score they have given has no relevance or purpose other than guiding discussion, and attempt to fully understand their concerns.

If you disagree with them and (after discussion) believe they are performing satisfactorily, advise them of this. If, however, you believe that there is an area/s of difficulty, discuss specific actions you will *both* undertake to address these problems. Is there a need to focus your teaching on a specific area? Does the trainee need more exposure or experience in specific clinical areas or clinical skills? Can you advise them how to enhance their learning in these areas? Are there professionals within or outside your organisation who might be of assistance? It is important that you *both* decide on specific actions to address these problems, set realistic objectives and time-frames, and agree to review progress in these areas on a regular basis, say fortnightly or monthly. Significant problems must be addressed before the next two-monthly formative interview.

It is *imperative* to take these steps in situations where a trainee's performance is sufficiently below standard that it is likely or inevitable that the final summative Supervisor's Report will give scores of 1 or 2 in any area. It is *entirely unacceptable* to give unsatisfactory final scores when no prior warning or discussion has occurred. *This does happen.* It is very difficult for the Faculty Education Committee to accept such an evaluation by the Clinical Supervisor when there is *no evidence* that the Clinical Supervisor has brought this problem to the trainee's attention, or initiated any form of remedial action.

A further note of caution: The trainee who globally self-evaluates their performance at **3** across all areas may be indicating their perception of generally average performance, but may be doing so without adequate personal reflection on both their strengths and weaknesses. Such global scoring can make it very difficult to initiate meaningful discussion. With an "all 3's" report, take the approach of examining each broad domain, encouraging the trainee to describe their performance and their level of confidence in each area. It is important to *open up* discussion in this way, and to attempt to identify areas of accomplishment and areas of need that can be dealt with as described above.

At the completion of the formative interview, the copy of the Supervisor's Report Form should contain the written comments of both Clinical Supervisor and trainee. Each should have a copy to be retained for the next interview. Where remedial action is necessary, a written plan is encouraged, detailing the specific problem areas, agreed goals, and timeframes. Both Clinical Supervisor and trainee should have signed copies of such a plan.

The record of each formative interview forms a template for each subsequent interview, and eventually underpins the end of term summative interview and report.

ACCREDITATION OF CLINICAL SUPERVISORS

The Faculty Education Committee recognises the importance of the Clinical Supervisor's role in assisting trainees to integrate theory into practice and to prepare for the reality of their future professional roles.

In order to demonstrate the Faculty's commitment to the provision of high quality clinical supervision and to recognize the contribution of Fellows performing this important role, the Accreditation Subcommittee of the AFRM Education Committee administers procedures on the basis of a 3-year cycle for the credentialing of Clinical Supervisors.

Every three years the Accreditation Subcommittee contacts all supervisors to remind them of their expected roles and the criteria for credentialing. New declarations of compliance are requested for accreditation status to be granted for the next three-year cycle.

Clinical Supervisors are granted credentialed status with the following obligations:

1. Familiarity with and fulfillment of Supervisor roles and responsibilities as outlined in the AFRM's Guide for Clinical Supervisors and in the Rehabilitation Medicine Training Requirements Handbook (2010);

2. At commencement of rotation Supervisor assists the trainee to formulate a learning agenda (e.g. a learning contract) and then set aside regular and devoted meeting/teaching times;

3. Work closely with trainee to identify and address any training or workload problems;

4. Completion of Supervisor's Report Form in a timely and comprehensive manner;

5. Communicate with the AFRM Education Committee (FEC) and or its Subcommittees regarding any matters of concern arising about trainee's performance in training or service roles;

6. Regularly attend (not less than once every 3 years) the Annual Scientific Meeting Supervisor's Workshop or an equivalent Clinical Supervisor's education program run by the RACP or equivalent specialist medical college;

7. Completion of a Supervisor's accreditation questionnaire (every 3 years);

8. Completion of the Training Facility Survey Form biannually (if applicable).

Recently admitted Fellows who are now supervising trainees and other Fellows who might not have trainees but request accreditation status as Faculty Supervisors are normally granted provisional accreditation for a period of twelve months (from the time of their request) during which time they are expected to attend an appropriate workshop.

THE PROFESSIONAL QUALITIES CURRICULUM

Introduction

This curriculum outlines the broad concepts, related learning objectives and the associated theoretical knowledge, clinical skills, attitudes and behaviours required and commonly utilised by all Physicians and Paediatricians within Australia and New Zealand, regardless of their area of specialty.

This curriculum complements learning objectives and competencies detailed in the Rehabilitation Medicine Training Program and is pitched at the standard consistent with that expected of a graduate trainee, accepting full responsibility for the patient's welfare and clinical care.

It is expected that all teaching, learning and assessment associated with the Professional Qualities Curriculum will be undertaken within the context of the Physician's everyday clinical practice and will accommodate discipline-specific contexts and practices as required. As such it will need to be implemented within the reality of current workplace and workforce issues and the needs of health service provision.

There may be learning objectives that overlap with or could easily relate to other domains; however, to avoid repetition, these have been assigned to only one area. In practice, however, it is anticipated that within the teaching/learning environment, the progression of each objective would be explored.

The Professional Qualities Curriculum outlines the range of concepts and specific learning objectives required by, and utilised by, all Physicians, regardless of their specialty or area of expertise. It spans both the pre-vocational and vocational training programs and is also utilised as a key component of the CPD program. The Professional Qualities Curriculum integrates and fully encompasses the diagnostic, clinical and educative-based aspects of the Physician's or Paediatrician's daily practice.

All aspects of the Professional Qualities Curriculum should be taught, learnt and assessed within the context of everyday clinical practice and, where appropriate, given a Rehabilitation Medicine specialty specific focus.

Expected Outcomes

Graduates from this training program will be equipped to function effectively within the current and emerging professional, medical and societal contexts. At the completion of their overall training program, it is expected that a new Fellow will:

• have demonstrated their knowledge of, and ability to competently utilise the range of common or generic knowledge, skills, attitudes and behaviours required by all Physicians or Paediatricians, regardless of their area of specialty

• be able to communicate effectively and sensitively with patients and their families, colleagues and other allied health professionals

• understand and acknowledge the importance of the various socio-economic factors that contribute to illness and vulnerability

• be aware of, and sensitive to, the special needs of patients from culturally and linguistically diverse backgrounds

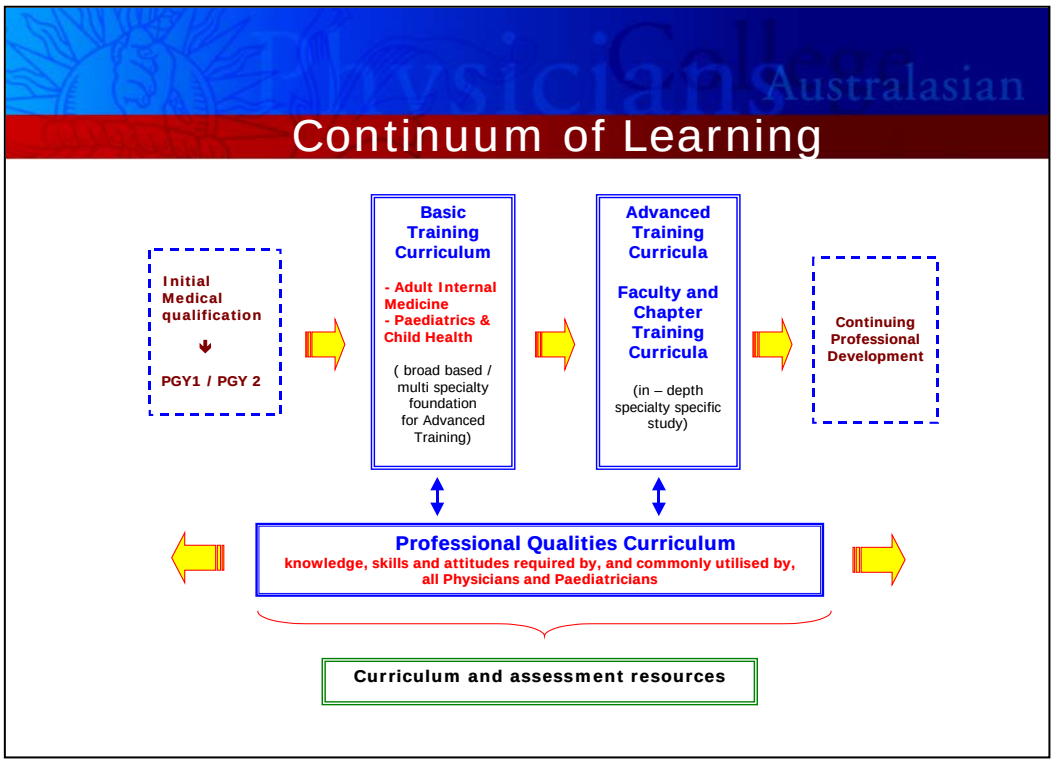
• be able to work within, lead and utilise appropriate multidisciplinary team-based approaches to the assessment, management and care of their patients

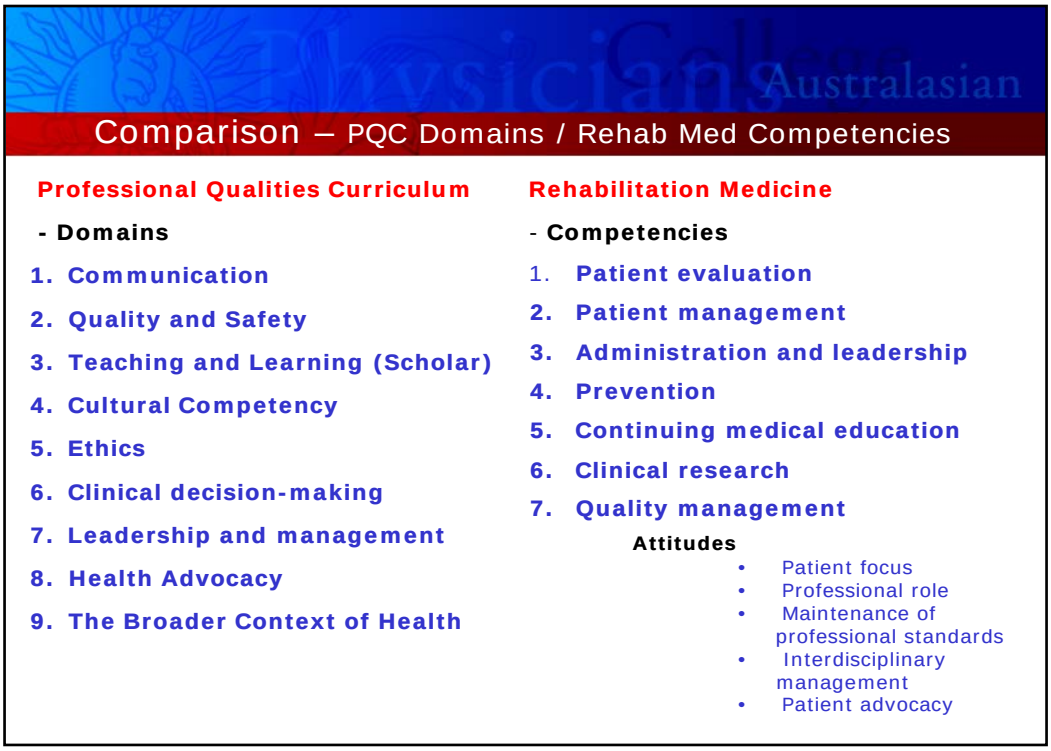
• recognise the need for, have developed, and be able to apply appropriate patient advocacy skills

• have the skills required to process new knowledge and the desire to promote and maintain excellence through actively supporting or participating in research and an active program of continuing professional development

• be able to contribute to the education of patients, colleagues, trainees, junior medical officers and other health care workers.

This curriculum can be downloaded from the *Physician Education* Section under the heading *Curriculum* on the College website http://www.racp.edu.au/





ATTACHMENT 1

STRUCTURE OF FACULTY EDUCATION COMMITTEES

Faculty Education Committee (FEC)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ To review and amend curriculum and teaching and learning processes in line with policies and procedures of the College Education Committee. ▪ To develop the content of examinations and other modes of assessment. ▪ To ensure the efficient management of examinations and assessment processes and the reporting of results. ▪ To certify to the Faculty Council that a trainee has successfully completed training in rehabilitation medicine. ▪ To advise the College Education Committee on any necessary changes to policy and procedures in assessment, teaching and learning, physician educators, and continuing professional development in rehabilitation medicine. ▪ To accredit sites and supervisors within the policy and procedures framework developed by the College Education Committee and approved by the College Board. ▪ To receive reports from the staff of the College and Office of the Dean to oversee the progress of Trainees and their adherence to approved pathways and to manage any necessary remedial action or support required by Trainees. ▪ To implement a staged grievance process in line with College policy and procedures. ▪ To be responsible for the activities of the Special Interest Groups (SIGs)	▪ Chairman ▪ Honorary Secretary ▪ Chair, Teaching & Learning Subcommittee ▪ Chair, Assessment Sub-Committee ▪ Chair, Accreditation Subcommittee ▪ Chair, Academic Rehabilitation Subcommittee ▪ Chair, Paediatric Training & Exams Subcommittee ▪ Chair, CPD Subcommittee ▪ Chair, Scientific Program Subcommittee ▪ Chair, Special Interest Groups ▪ Trainee Representative ▪ Ex-officio members (including Coordinator of Education)	2 or 3 face-to-face meetings annually and up to 4 meetings by teleconference.	AFRM Council & College Education Committee	Subcommittees: Teaching & Learning Academic Rehabilitation Assessment Accreditation Paediatric Rehabilitation Advanced Training CPD Special Interest Groups Scientific Program

Teaching & Learning Training Subcommittee (TLC)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ Responsible to the Faculty Education Committee for the teaching and learning activities in the Rehabilitation Medicine training program of the AFRM ▪ To develop, implement and evaluate new training modules for approval by the Education Committee	• Chair (sits on FEC and Teaching and Learning Expert Advisory Group) • Honorary Secretary • Assistant Honorary Secretary • Branch Training Coordinators (6) • Trainee Representative • Coordinator of Education	The Honorary Secretary meets with Faculty Office staff on a fortnightly basis to carry out delegated duties. Full committee has 6 teleconferences annually	Faculty Education Committee	

Continuing Professional Development Subcommittee (CPDC)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ Organise and administer the Faculty's Continuing Professional Development program ▪ Assessment, approval and rating of educational activities and QA activities ▪ Disseminate information to all Fellows regarding Continuing Medical Education and Quality Assurance activities and requirements. Ensure that all Fellows are aware of their responsibilities and of the opportunities to meet these responsibilities in these areas	• Chair (sits on FEC and CPD Expert Advisory Group) • CPD Coordinator • SIGS Coordinator (corresponding member) • Representatives from each State / Branch • Paediatric Representative • Ex-officio members	2 face-to-face meetings annually and 3 meetings by teleconference.	Faculty Education Committee	

Assessment Subcommittee

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ Responsible for formative and summative assessment of candidates for FAFRM ▪ Recommend the suitability of an applicant for Fellowship to the AFRM Committee and thus to Council ▪ Set and convene the Fellowship examinations ▪ To set and convene the Rehabilitation Medicine Training Program's assessment modules 1 and 2 ▪ To coordinate External Training Modules 3-6	▪ Chair (sits on FEC and Assessment EAG) ▪ Clinical Examinations (FCE) Convenors (3) ▪ Module 1 Convenor ▪ Module 2 Convenors (3) ▪ Fellowship Written MCQ Convenor ▪ Fellowship Written Short Essays Convenor	One face-to-face meeting (August), one Workshop (December) & 5 teleconferences annually	Faculty Education Committee	Working Parties for: FCE MCQ Written Essays Module 1 Module 2 Modules 3-6 Long Case Assessments

Accreditation Subcommittee

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ Responsible to the Faculty Education Committee for the accreditation of suitable training sites ▪ Responsible for the accreditation of Trainers and Faculty Supervisors	▪ Chair (sits on FEC and Accreditation EAG) ▪ Branch representatives ▪ Trainee Representative	One face-to-face meeting and up to 4 meetings by teleconference.	Faculty Education Committee	Site Accreditation Working Parties

Paediatric Rehabilitation Advanced Training Committee (PRTC)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ Responsible for all Paediatric Rehabilitation Medicine training activities ▪ Assessment of those who wish to apply for Fellowship in Paediatric Rehabilitation Medicine either by examination or by other means. ▪ Responsible for the development, implementation and evaluation of relevant training modules as approved by the Education Committee.	▪ Chair (sits on FEC) ▪ Honorary Secretary ▪ Elected Members (4): NSW (2)/SAWA ▪ Trainee Representative	One face-to-face meeting and 4 teleconferences annually.	Faculty Education Committee	Written & Clinical Examination Working Parties

Academic Rehabilitation Subcommittee

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ To establish and develop an academic Rehabilitation Medicine capability in Australia and New Zealand ▪ To develop a strategy which will assist in the development of academic centres of excellence for Rehabilitation Medicine in Australia and New Zealand ▪ To develop partnerships with international organisations of Rehabilitation Medicine research excellence ▪ To support the education and training process for trainees in research ▪ To identify barriers to research and provide a pathway for new researchers in Rehabilitation Medicine ▪ To identify and assist researchers in areas of funding opportunities	▪ Chair (sits on FEC) ▪ Honorary Secretary ▪ New Fellow member ▪ Paediatric Rehabilitation member ▪ International member ▪ Ex-officio members	2 face-to-face meeting annually and up to 3 meetings by teleconference.	Faculty Education Committee	

Scientific Program Subcommittee (CPDC)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ To coordinate the organisation of the Faculty's Annual Scientific Meetings (ASM)	▪ Chair (sits on FEC) ▪ 2 academics (not from the same state) ▪ SIG Coordinator ▪ 1 Paediatric Representative ▪ 3 ASM organisers (Chairs of the previous, current & subsequent year's ASM organising Committees ▪ Ex-officio members	1 face-to-face meeting annually and other meetings by teleconference as required.	Faculty Education Committee & RACP Conference Program Committee	ASM Local Organising Committees

Special Interest Groups Subcommittee (SIGs)

Key areas of responsibility	Membership	Frequency of meetings	Reports to	Sub groups
▪ The collection, propagation, and dissemination by and amongst members of the Special Interest Group of scientific knowledge, information and data and such analogous scientific and incidental purposes as the Council may approve ▪ To be agents for information and advice (to FEC, Council and Executive) in the particular area of interest, with each SIG Chairman acting as the adviser for issues in their area of expertise	▪ Chair of all SIGs, nominated by other SIG Chairs (sits on FEC) ▪ SIG membership open to all Faculty Fellows and Trainees with an interest in the area defined by the Special Interest Group. ▪ Each SIG must have a Chairman and Honorary Secretary	SIG Chairs meet up to 3 times a year by teleconference. Individual SIGs meet by teleconference as required with annual face-to-face meeting during ASM.	Faculty Education Committee	10 Special Interest Groups

ATTACHMENT 2

CHECKLISTS FOR EDUCATORS IN THE HEALTH PROFESSIONS

We would like to acknowledge the primary source of this document: the Centre for Instructional Support (CIS), and the University of Colorado Health Sciences Centre. The website is: www.uchsc.edu/CIS. This site presents information and resources for helping health professions to enhance their instructional, leadership/management, and research skills, and has additional resources that can help with career development.

Assessing the Effectiveness of a Learning Plan

A Self-Checklist

Learning goals: Are the goals:

- ☐ clearly stated?
- ☐ appropriate and realistic for the learner's experience and stage of development?
- ☐ doable in our setting with our resources?
- ☐ comprehensive (i.e., include goals from the cognitive, affective, and psychomotor domains)?
- ☐ worthwhile (are they relevant; do they include complex, difficulty-to-describe outcomes)?
- ☐ regarded as evolving and modifiable?

Learning strategies: Will the

- ☐ learning strategies support and be consistent with the learning goals?
- ☐ learner have adequate opportunities to watch me &/or others demonstrate any needed complex skills?
- ☐ learner have adequate opportunities for systematically practicing what she or he needs to learn?
- ☐ learner be making full use of available resources?
- ☐ learner have sufficient time for both input and reflection?

Strategies for monitoring the learner's progress: Are there provisions for

- ☐ gathering information about the learner's relevant entry-level capabilities?
- ☐ me to routinely observe the learner's performance?
- ☐ videotaping the learner's performance (e.g., some of his or her interactions with patients/clients)?
- ☐ gathering information from others who are in a position to provide helpful feedback (e.g. other teachers, peers, patients)?
- ☐ quickly giving the learner information gathered from others?
- ☐ adequate opportunities for the learner to critique his or her performance and progress?
- ☐ adequate opportunities for me to give feedback to the learner?
- ☐ the learner and me to have frequent supervisory sessions?

Other: Are

- ☐ the learner's roles and responsibilities clearly spelled out?
- ☐ my roles and responsibilities clearly spelled out?
- ☐ the ground rules for the ways the learner and I will work together spelled out, if appropriate?

Adapted from: Westberg, J., Jason, H. *Collaborative Clinical Education: The Foundation of Effective Health Care,* New York: Springer Publishing, 1993.

Providing Constructive Feedback

A Self-Checklist

KEY: **A = Always F = Frequently 0 = Occasionally N = Never**
For each item, circle the letter that applies.

To what extent do 1...

A F 0 N 1. establish and maintain a climate of trust in which learners welcome and invite feedback?

A F 0 N 2. arrange the proper setting for providing feedback?

A F 0 N 3. begin by inviting the learner's self-assessment?

A F 0 N 4. ensure that learners identify both what they did well as well as areas needing further work?

A F 0 N 5. ensure that my feedback is timely?

A F 0 N 6. link my feedback to each learner's goals?

A F 0 N 7. link my feedback to my actual observation of learners?

A F 0 N 8. check out any hypotheses I generate about each learner's performance?

A F 0 N 9. present feedback in nonjudgmental language, being as specific as possible?

A F 0 N 10. present learners with objective evidence whenever possible?

A F 0 N 11. focus on each learner's behaviour and performance, not judgments about them as people?

A F 0 N 12. label my feedback as subjective, when it is?

A F 0 N 13. avoid overloading learners with feedback?

A F 0 N 14. recognize that learners have varying levels of receptivity to feedback?

A F 0 N 15. convey support when providing feedback?

A F 0 N 16. avoid premature feedback?

A F 0 N 17. help learners turn negative feedback into constructive challenges?

A F 0 N 18. encourage learners to invite feedback; to let me know when it is difficult to hear my feedback?

A F 0 N 19. provide follow-up to my feedback, whenever appropriate?

Adapted from: Westberg, J., Jason, H. *Collaborative Clinical Education: The Foundation of Effective Health Care,* New York: Springer Publishing, 1993.

Characteristics of Effective Clinical Teachers

A Self-Checklist

KEY: **A = Always F = Frequently 0 = Occasionally N = Never**
For each item, circle the letter that applies.

To what extent...

A F 0 N 1. do I have the ability to handle - even to thrive in - the "messy" world of clinical teaching?

A F 0 N 2. do I enjoy and respect people?

A F 0 N 3. am I interested in and committed to being helpful to patients, students, and residents?

A F 0 N 4. do I have the capacity to work collaboratively with others?

A F 0 N 5. am I sensitive to the subtleties of human functioning involved in patient care and teaching?

A F 0 N 6. am I enthusiastic about my subject?

A F 0 N 7. am I enthusiastic about teaching?

A F 0 N 8. do I enjoy - and am good at - learning?

A F 0 N 9. am I able to convey my enthusiasm for teaching, learning, and my subject?

A F 0 N 10. am I reflective about what I do as a clinician and teacher?

A F 0 N 11. am I willing to admit my limitations?

A F 0 N 12. am I open to challenges to the way I do things?

A F 0 N 13. am I adaptable?

A F 0 N 14. am I willing to make needed changes?

A F 0 N 15. am I able to deal constructively with ambiguity and uncertainty?

A F 0 N 16. is what I say congruent with what I do (do I practice what I preach)?

Adapted from: Westberg, J., Jason, H. *Collaborative Clinical Education: The Foundation of Effective Health Care,* New York: Springer Publishing, 1993.

Questions to Ask About a Precepting Assignment

A Self-Checklist

- ☐ What are the characteristics of the learner (e.g., background, special interests)?
- ☐ What does the training program expect the learner to do during the CLE*?
- ☐ Does the learner have learning goals - and if so, what are they?
- ☐ Does the learner have a learning plan - and if so, what is it?
- ☐ What are the learner's current skills that are relevant for this CLE?
- ☐ How is the training program preparing the learner for the CLE?
- ☐ What am I expected to do before, during, and after the CLE?
- ☐ How will this CLE fit into the learner's overall curriculum?
- ☐ What provisions can be made so I can observe the learner in action and hold regularly supervisory sessions?
- ☐ How will I interact with the faculty from the learner's program/school (e.g., Will a faculty member visit me during the CLE?)
- ☐ What kinds of support will I be given in preparing for and carrying out my teaching responsibilities? (e.g., a Supervisor's workshop
- ☐ What are the mechanisms for evaluating my teaching and providing me with helpful feedback?

CLE = Clinical Learning Experience (i.e. rotation or term of training)

Adapted from: Westberg, J., Jason, H. *Collaborative Clinical Education: The Foundation of Effective Health Care,* New York: Springer Publishing, 1993.

Giving Feedback to Learners

(e.g. following an In-Training Long Case Assessment)

A Self-Checklist

Do I ...

- ☐ Establish and maintain a climate of trust in which learners welcome, even invite, my feedback?
- ☐ Make sure learners understand that I will provide feedback to them during review sessions - and how?
- ☐ (If video was used) Signal the learner to stop the tape, if not already done, when I see an event I want to discuss?
- ☐ Begin by inviting the learner's self-assessment?
- ☐ As much as possible, help learners make their own discoveries?
- ☐ Link my feedback to the agreed upon goals when possible?
- ☐ Focus on learners' behaviours and performances, rather than making judgments about them as people?
- ☐ Try to be as specific as possible, referring the learner to explicit events when possible?
- ☐ When possible, begin my feedback with positive observations?
- ☐ Avoid following my positive observations with "but..." and a negative observation?
- ☐ Give learners a language with which to reflect on their performance?
- ☐ When my feedback is subjective, label it as such?
- ☐ Avoid overloading learners with feedback?
- ☐ Demonstrate support for learners when providing feedback?
- ☐ Attend to both *what 1* say and how I say it?
- ☐ Invite the learner's reaction to my feedback?
- ☐ Help learners turn negative feedback into constructive challenges?
- ☐ Encourage learners to invite my feedback and to let me know when it is difficult to hear my feedback?
- ☐ Provide follow-up to my feedback when appropriate?
- ☐ Take notes on the supervisory session to guide future encounters with the learner?

Adapted from:

Westberg, Jane and Jason, Hilliard. *Teaching Creatively with Video: Fostering Reflection, Communication, and other Clinical Skills,* New York: Springer Publishing, 1994.

Giving Feedback to Peers

A Self-Checklist for Learners

Did I ...

- ☐ Find out what my colleague was trying to accomplish in the encounter I witnessed?
- ☐ Find out if there were any special issues our colleague wanted us to focus on in the review session?
- ☐ Invite my colleague's self-assessment before providing my feedback?
- ☐ Try to facilitate my colleague's own discoveries wherever possible?
- ☐ Regard the review as a time to be helpful to my colleague, not to display my insights and expertise?
- ☐ (In clinical situations) Try to keep the provision of high-quality health care as an overriding concern?
- ☐ Check out my hypotheses about my colleague's behaviours before making pronouncements?
- ☐ Before giving feedback, think through how I would feel receiving these comments?
- ☐ Present feedback in non-judgmental language?
- ☐ Try to be as specific as possible, referring my colleague to explicit events, when possible?
- ☐ Focus on my colleague's behaviour, rather than making judgments about him or her as a person?
- ☐ When my feedback was subjective, label it as such?
- ☐ Provide feedback on my colleague's strengths and accomplishments as well as weaknesses and errors?
- ☐ Avoid overloading my colleague with feedback?
- ☐ Demonstrate support for my colleague when providing feedback?
- ☐ Help my colleague turn negative feedback into constructive challenges?
- ☐ Encourage my colleague to invite my feedback and to let me know when it is difficult to hear my feedback?
- ☐ Provide follow-up to my feedback when appropriate?

Adapted from:

Westberg, Jane and Jason, Hilliard. *Teaching Creatively with Video: Fostering Reflection, Communication, and other Clinical Skills***,** New York: Springer Publishing, 1994.