FACULTY OF HUMANITIES AND SOCIAL SCIENCES
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Clinical supervision of junior doctors:
Every interaction matters one way or the other

UTS
THINK.CHANGE.DO

Hospital After Hours Conference
Sydney

29-30 May 2008

Session 7: Nursing workforce and skill mix

Collaborative research

UTS Centre for Health Communication
NSW Institute of Medical Education and Training
Port Macquarie Base Hospital [in Hospital Alliance for Research Collaboration (HARC) network]
North Coast Area Health Service
Sax Institute

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Dr Michael King, DMS, PMBH
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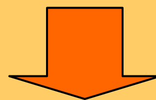
Why this pilot study of junior doctor clinical supervision?

- Patient safety and reducing adverse events are a priority issue (raised by NSW Clinical Excellence Commission and clinicians)
- Link between clinical supervision of junior doctors and quality of patient care
- Involving JMOs, Registrars, Consultant supervisors



- Pilot study 'deliverables':
  - defining a 'model of effective clinical supervision'
  - educational material
  - larger study and research program

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Junior Doctor clinical supervision research program 2007-2011

Pilot study achieved

Oct 07-Apr 08

Exploratory phase
Definitive phase
(Grounded theory)
Model of effective clinical supervision
Draft educational material

[rural hospital]

Pre-test phase proposed

2008-2009

Case studies
Model of effective clinical supervision
Evaluation

[metropolitan hosps]

Implement-ation phase planned

2009-2011

Case control study
Longitudinal study
Policy and Curriculum development
Clinical practice

Pilot site: Port Macquarie Base Hospital

Referral hospital for the Hastings Macleay Network. Commissioned Nov 1994
161-bed facility that provides base hospital services for the growing communities of Port Macquarie, the Hasting and Macleay Valleys.

Patients	1Jan-31Mar	1July-30Sept
Male	1650 (48.3%)	1798 (47.1%)
Female	1764 (51.7%)	2020 (52.9%)
Total	3414	3818

PMBH facilities include:
24-hour Emergency Services
4 Operating Theatres;
3 Birthing Rooms;
Rehabilitation facilities, including a Hydrotherapy Pool;
On-site facilities include Pharmacy; Pathology; Medical Imaging; Day Hospital and Allied Health Services; Pre-admission Clinic, Day Procedures; Express Community Care Centre; Community Mental Health Service; North Coast Cancer Institute; Breast Screen NSW; University of NSW; Southern Cross University

9 Wards:

1A	Psychiatric Unit
1B	Medical/Rehabilitation
1C	Medical/Palliative Care
2A	Obstetrics/Special Care Nursery
2BP	Paediatric/Adolescent Unit
2BS	Transit Lounge/Short Stay Ward.
2C	Surgical/Orthopaedics
C/ICU	Coronary /Intensive Care Unit
ED	Emergency Department

6 Divisions:
Medicine
Surgery
Orthopaedics
Paediatrics and Obstetrics/Gynaecology
Psychiatry
Emergency

Ref: PMBH JMO Handbook 2008

Literature Review I informing the Exploratory phase of the Pilot study

Supervision defined

‘The provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainee’s experience of providing safe and appropriate patient care.’ (Kilminster et al. 2007)

…and informally, socially, phone, and ‘on the run’

‘*Clinical Supervision* is the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the clinician in their professional environment.’ (WA Dept Health)

Teaching and learning

‘A process of cooperative interaction for the purpose of helping the learner change their knowledge, skills, attitudes, behaviour.’ (Snell, 2006)

and supervisor … [bi-directional learning]

Wu et al (2003) surveyed 254 internal medicine house officers, **N=114 (45%RR)** – anonymous questionnaire describing **their most significant mistake and their response to it.**

Patients had serious adverse outcomes in 90% of cases (death in 31% of cases)

Mistakes included:
Errors in diagnosis (n=38;33%)
Prescribing (n=33;29%)
Evaluation (n=24;21%)
Procedural complications (n=13;11%).
Communication (n=6;5%)

Only 54% of HOs discussed the mistake with their attending physicians, and only 24% told the patients or families

'Decreasing work load and closer supervision may help prevent mistakes.'
'Encourage [junior doctors] to accept responsibility and to discuss their mistakes = promotes learning and constructive changes in practice.'

[A safe, trusting supervision relationship is critical!]

Wu, AW, Folkman, S, McPhee, SJ, Lo, B. Do house officers learn from their mistakes? Q*ual Saf Health Care* 2003;12:221-226.

Literature Review I
informing the exploratory phase:
Quality of the supervision relationship and interaction

"The supervision relationship is probably the single most imp... ...or the effectiveness of supervision, more important than th... methods used." Kilminster & Jolly (2000;833) Literature review

"The quality of supervisory interactio... ...epth." (Kilminster & Zukas, 2005)

Closer supervision... ...stakes and help prevent them [JMO ac... ...] (Wu, Folkman, McPhee, Lo, 2003)

...visor and junior doctor (Todd & Freshwater, 1999; ...

"....t... ...cle that results when attending physicians fail to provide effective super... Not only is safety compromised but trainees lose the experience of being supervised." (Shojania et al, 2006) *Graduate Medical Education and Patient Safety: A busy - and occasionally hazardous - intersection*

Research problem

How do we turn these research and evidence-based critical elements of clinical supervision into an effective model for busy supervisors and junior doctors?

Questions…questions...questions...

- What is the supervision context? …what does supervision ‘look like’ in a rural hospital setting?
- How many interactions take place over a day, a week, a fortnight….? …what is the quality of those interactions?
- Who is present at the supervision interactions?
- What is the quality of the supervision relationship?
- What impact do those supervision interactions have on the supervision relationship? …..on the supervisor? ….on the junior doctor? …. on patient care?
- What information do we need to progress to the Definitive phase of model development (using Grounded theory)? .....

Overview of the methods

Qual+Quant Methods and Data collection

EXPLORATORY PHASE → **DEFINITIVE PHASE**

Pre-study questionnaire

Q.1 How would you define 'clinical supervision'?
Q.2 For you, what makes clinical supervision 'ineffective'?
Q.3 For you, what are three key elements of 'effective' clinical supervision?
Q.4 What three things do you bring to the clinical supervision process?
Q.5 What three things do you expect to derive from the clinical supervision process?

Field note "diary" over 14 days using the **Supervision Interaction Grid**

Grounded theory analysis

Post-study – reflective practice exercise
Q.1 On reflection of your clinical supervision experience at PMBH, please elaborate on **at least one interaction which stood out from the rest.**
Q.2 In addition, please draw on **past experiences at other hospitals** in relation to what you consider to be 'ineffective' and 'effective' clinical supervision.
Q.3 Based on your supervision experiences at PMBH and elsewhere, could you please elaborate on **what may be helpful in preparing others** for their first experience of clinical supervision (including junior doctors and supervisors).
Q.4 Please provide final **comments and suggestions** as we move towards developing both a 'model of effective clinical supervision', and educational material.

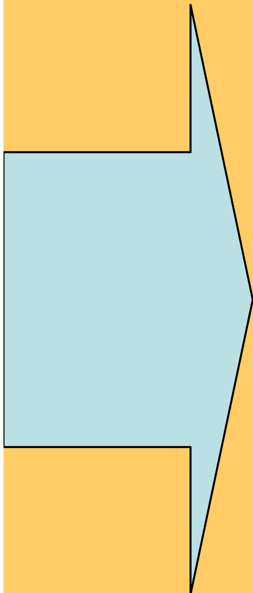
Field notes and data collection

JMO perceptions of supervision interactions

Findings from Exploratory phase

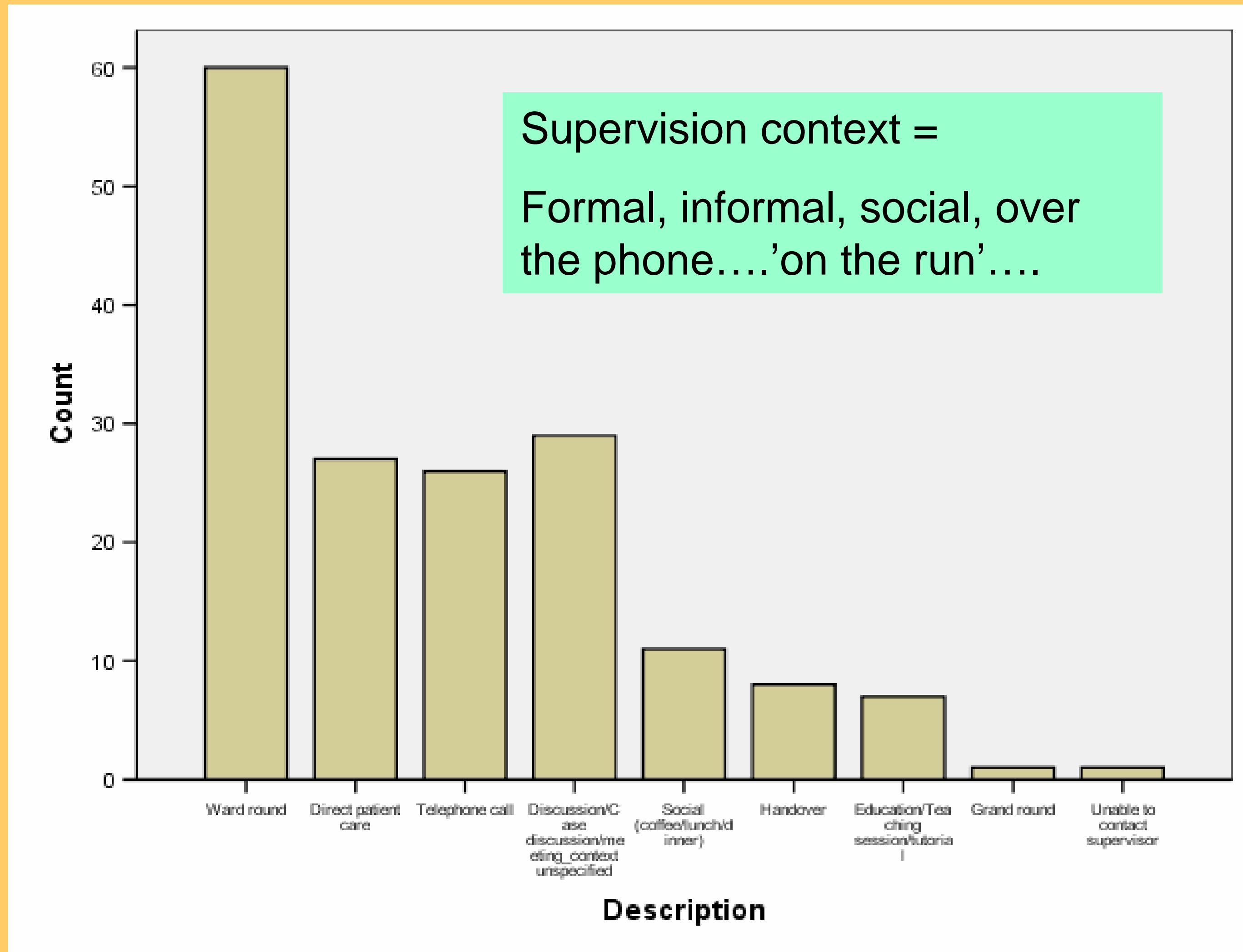
Where did supervision take place?

Supervision interactions perceived as positive or negative



5 JMO reported 170 supervision interactions over 14 days	n (%)	Perceived as positive	Perceived as negative
Ward round	60 (36%)	52 (87%)	8 (13%)
Direct patient care	29 (18%)	27 (93%)	2 (7%)
Telephone call	26 (15%)	24 (92%)	2 (8%)
Discussion/Case discussion/meeting (context unspecified)	26 (15%)	20 (77%)	6 (23%)
Social (coffee/lunch/dinner)	11 (6%)	11 (100%)	-
Handover	9 (5%)	9 (100%)	-
Education/teaching session/tutorial	7 (4%)	6 (86%)	1 (14%)
Grand round	1 (.5%)	1 (100%)	-
Unable to contact supervisor	1 (.5%)	-	1 (100%)
JMO total interactions	**170 (100%)**	**150 (88%)**	**20 (12%)**

JMO Supervision description



Who was present at the supervision interaction?

Present at supervision interaction

		Frequency	Percent
1	JMO alone	5	2.9
2	JMO+Registrar	55	32.4
3	JMO+Consultant	40	23.5
4	JMO+Registrar+Consultant	29	17.1
5	JMO+Registrar+Patient	3	1.8
6	JMO+Pts family	1	.6
7	JMO+Registrar+student	1	.6
8	JMO+ICU doctor+nurses	1	.6
9	JMO+ICU doctor	2	1.2
10	JMO+Registrar+Consultant+other doctors	2	1.2
11	JMO+Radiologist+other junior doctors	1	.6
12	JMO+Registrar+Consultant+Consultant	1	.6
13	JMO+Consultant+Patient	3	1.8
14	JMO+Consultant+Consultant	4	2.4
15	JMO+Nursing staff+Consultant	1	.6
16	JMO+Nursing staff+Registrar	1	.6
17	JMO+Nursing staff+Registrar+AHP	2	1.2
18	JMO+MDT/AHP+Registrar+Consultant	1	.6
19	JMO+Consultant+Registrar+Patients	1	.6
20	JMO+Consultant+AHP+Registrar	1	.6
21	JMO+all Consultants+Registrar	1	.6
22	JMO+MDT+Registrar+Consultant	2	1.2
23	JMO+Registrar+MDT	1	.6
24	JMO+MDT	1	.6
25	JMO+Registrar+CNC	1	.6
26	JMO+Dentist	1	.6
27	JMO+Radiologist	3	1.8
28	JMO+Registrar+Registrar+Registrar+Medical student	1	.6
29	JMO+Consultant+Registrars+Midwives+others	1	.6
30	JMO+Consultant+Residents+Interns	1	.6
31	JMO+Consultant+Consultant+Consultant	1	.6
32	JMO+Nurse educator+Interns+Residents	1	.6
	Total	**170**	**100.0**

Adding meaning to the stats…..

Putting ourselves in the shoes of a Junior Medical Officer

Putting ourselves in the shoes of a Consultant Supervisor

Definitive phase of the Pilot study: Grounded theory analysis

JMOs association between positive and negative perception to 'effective' and 'ineffective' clinical supervision….

INEFFECTIVE	EFFECTIVE
Angry; Embarrassed; Frustrated; Abandoned; No teaching education; Organised and fast, no educational benefit; Supervisor dismissive of clinical question; Felt isolated and unsure; Minimal effect; Repetitive information given; Insulted; Registrar unhelpful; Mocked; Unable to contact any senior staff; Minimal interaction; Overwhelmed; Registrar did not listen; Limited learning due to time constraints; Unsuccessful attempt [at procedure]; Was told performance was disappointing but not given chance to explain; Supervision of [procedure] unsuccessful; Poor advice given; Felt very unsupported; Areas of conflict which were uncomfortable; etcetera	Felt respected; Satisfaction at job well done; Gained insight; Challenging; Good team work; Informative; Confidence-boosting; Good education; Interactive; Feedback on performance; Learning experience; Praise; Appreciative; Enjoyable; Felt supported; Some negotiation of management decisions; Practical education; Social; Guided; Good involvement; Opportunity to discuss; Excellent learning; Good opportunity to witness consultation with Consultant; Easily contactable; Opportunity for direct experience; felt in control; Good working relationship; [technical] advice…done satisfactorily independently; Disappointment at not being able to have a chance to perform; Good insight; etcetera

How do these descriptors compare with JMOs' pre-study definitions of 'effective' and 'ineffective' clinical supervision?

Pre-post shift in ‘definition’?

Q1 – Define ‘clinical supervision’

Advice, practical help, information, guidance, support, presence, overseeing decisions, input, teaching, constructive feedback, mentor…

Q2 – ‘Ineffective’ clinical supervision

Not satisfying the needs of the junior, unapproachable, difficult to contact, doubtable knowledge/decisionmaking ability, overly critical, lack of time, unreachable, unavailable, too busy to respond, uncertainty as to who to contact, poor communication, non-supportive environment…

Q3 – ‘Effective’ clinical supervision

Advice, approachability, communication, availability, feedback on performance, explanations for decisions, informal teaching, trust, being honest…

Q4 – What JMOs bring to clinical supervision

Willingness/eagerness to learn/ask, honesty, flexibility, communication, being open to learning and constructive criticism, good oral and written communication skills, clinical skills, knowledge of own limitations, recognising when I need to ask for help, reliability, ability to ask questions and admit gaps in knowledge…

Q5 – Expecting to derive from clinical supervision

Knowledge, learn/improve/further medical knowledge, good outcome for patients, support, experience, more confidence in work/abilities/to deal with problems/managing patients, education/teaching, practical skills, improved happiness/satisfaction at work, insight into areas needing to work harder on…

JMO’s responses more subjective/emotive using Supervision Interaction Grid and reflective practice exercise with reference to impact of the supervision relationship

eg ‘being mocked’, ‘felt abandoned’, ‘felt isolated’, ‘felt in control’…

Literature review II: Definitive phase….

How does the literature on clinical supervision fit with the Supervision Interaction Grid?

Grounded theory……
an iterative process

Review of Pilot Phase

- ☑ Increased understanding of **levels of quality** of supervision relationship
- ☑ Insight to **impact** of supervision interactions
- ☑ Reflective practice taps into **more complex emotions** and issues surrounding the supervision relationship
- ☑ Points to issues that could **compromise patient safety** eg difficult relationships, difficult emotions
- ☑ **Association** between **negative** and **positive** perceptions of interactions and **'ineffective'** and **'effective'** clinical supervision
- ☑ Emerging issues eg difference between rural and metropolitan contexts of clinical supervision, link between quality of relationship and receptivity and transfer of skills, role of peer support mechanisms….

☑ **EVERY SUPERVISION INTERACTION MATTERS…**
ONE WAY OR THE OTHER!

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Thank you for your attention!

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