THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

# Guidelines for Supervision

## Background

Within medical practice, various forms of supervision exist for all physicians: by local institutional structures; group practice accountabilities; employer-employee relationships; or the overarching accountability within the professional regulatory framework. For most doctors, the supervision is subtle and unobtrusive – the College takes a role in setting standards and best practices, investigating complaints, and conducting practice-based assessments. For some doctors, supervision is more involved and structured with frequent interaction and reporting relationships. Most supervision is time-limited and is designed with a graduated model of increasing independence and delegation. The intended outcome is almost always to gradually removal the supervisor and return the physician to a fully independent practice; but the best interests of patients must always be considered first and foremost.

## How these guidelines can help

Supervision can be a positive experience. The College is interested in keeping physicians in practice, except those who exhibit egregious behaviour or incompetence. Sometimes, physicians are in need of closer monitoring and a period of education to improve to the expected level of care. Supervision sometimes complements an educational process and safeguards the public from the possibility of inadequate medical care. The guidelines will help the College and universities to determine the nature, scope and frequency of the supervision required under the particular presenting circumstances. They will also set clear expectations for physicians who may fit into one of the supervision categories, and help supervisors and the supervised physician to understand their respective roles and responsibilities. When applied in a consistent and responsible manner, supervision will ensure the continued delivery of the best quality care for the people of Ontario by the doctors of Ontario.

In two other policies on supervision (*Professional Responsibilities in Postgraduate Medical Education; and Professional Responsibilities in Undergraduate Medical Education*) the College has set out principles for supervisors. With modifications, these principles are outlined below.

1. The best interests of the patient are central to all physician-patient interactions.
2. The practice of medicine is inherently uncertain and there is a level of risk associated with all patient care decisions. Risk is reduced through the proper application of knowledge, skill and judgement.

3. Respect for the autonomy and personal dignity of the patient and physician optimizes patient care as well as the supervisory experience.

4. Clear delineation of the most responsible physician, decision-making and exchange of information between supervisor and physician will obtain the best results from the supervisory experience.

5. Physician improvement (practice relationships, enhanced clinical skills) is facilitated by his or her active involvement in the provision of health care with hands-on delivery in a system of delegated and graded responsibility.

**Definitions**

**Most Responsible Physician ("MRP")** is the physician who has final responsibility for making decisions about the care of a patient.

**Postgraduate Clinical Trainees** ("trainees") are doctors who hold a degree in medicine and are continuing in specialist education, including family medicine. They are members of the College of Physicians and Surgeons of Ontario with an educational certificate of registration and are bound by the legislation and policies of the College.

**Supervision** is the act of one or more physician(s) overseeing the work of another, where the level of oversight will be defined as low, moderate or high. In almost all circumstances contemplated in these guidelines, supervision will be time-limited. The level of interaction between supervisor and supervised physician will depend on the specific circumstances.

**Supervisors** are physicians who are approved by a College committee, University or other agency responsible for the supervision requirement. The supervisor may or may not be the most responsible physician. Supervisors must always be members in good standing of the College of Physicians and Surgeons of Ontario. The term supervisor may be used interchangeably with practice monitor, preceptor, or trainer.

Note: The term supervisor is sometimes used interchangeably with other terms, such as practice monitor, preceptor, or trainer. These terms are all different levels of "supervision" and will be distinguished by the nature of the supervision. In addition, an educational process, with or without the active participation of the designated supervisor, is often an important component for a successful supervision arrangement.

| ***Characteristics of an acceptable supervisor*** | ***Responsibilities of a supervisor*** |
|---|---|
| ➢ Ontario registration for independent practice;<br>➢ Practicing in Ontario;<br>➢ CMPA member;<br>➢ Good standing with College - minimum three consecutive years in independent practice in Ontario;<br>➢ Medical practice matched to scope of practice of physician - may include same specialty designation;<br>➢ Experience in, or willingness to learn about, the education and evaluation of practising physicians;<br>➢ Affiliations with relevant institutions in the community of practice;<br>➢ Able to provide constructive/honest feedback to physician and College;<br>➢ Strong sense of professional responsibility and commitment to peer support;<br>➢ Active in professional development;<br>➢ Willingness to comply with all terms of the College agreement. | ➢ Verify that physician practices only in approved setting and context;<br>➢ Verify that patient care provided by the physician meets the expected standard of care;<br>➢ Provide direct and immediate feedback to the physician that is constructive, objective and honest;<br>➢ Maintain appropriate boundaries with the physician, respecting the role of the supervisor as an agent of the College;<br>➢ Provide reports at prescribed intervals, as required;<br>➢ Establish a supportive, collegial and professional relationship with the physician to facilitate success;<br>➢ Report immediately to the College any dangerous or unsafe practices by the physician, or any apparent breaches by the physician of his or her obligations to the College;<br>➢ Be aware of real or perceived biases in relationship with physician. |
| ***Responsibilities of the supervised physician*** | ***Patient consent*** |
| ➢ Motivated to, and takes responsibility for, improvement;<br>➢ Respect for the interests of patients and their appropriate care and treatment;<br>➢ Open and honest with his or her colleagues and supervisor to facilitate the educational and supervision process;<br>➢ Actively participates in all educational and practice activities that will lead to a return to independent practice;<br>➢ Respect and collegiality toward the supervisor;<br>➢ Demonstrates meaningful signs of progress toward meeting College expectations. | ➢ Patients or substitute decision-makers are always participants in their care decisions;<br>➢ Explicit patient consent may be necessary for the supervisor to fulfill his or her role;<br>➢ Patient is fully informed if a supervisor is participating in the patient-doctor interaction;<br>➢ Patient consent can be withdrawn at any time. |

**How to develop an effective supervision plan**

Supervision is necessary when there is a level of risk to patient safety that is over and above the inherent level of risk of practicing medicine. When the factors change, the level of risk changes. This may be due to incomplete qualifications, demonstrated deficiencies as determined by assessment, or a pattern of conduct and behaviour that is by all accounts unacceptable, but potentially remediable. The public expects that there will be a level of oversight and supervision to assure appropriate patient care until education and improvement adjust the risk factors.

Beginning to understand the concept of risk and responding with supervision requires consideration of four key areas.

1. Understand the elements of practice (the scope)
   - The doctor – what is his/her training and experience;
   - The patients – patient demographics, conditions, acuity, etc.;
   - The environment – office, institutional, community, resources available, consultants available, etc.

2. Define the objectives of supervision (accountability for the physician)
   - To prepare for the completion of qualifications – resident, new entrant who requires completion of certification examinations;
   - To participate in educational or remedial programs;
   - Will the doctor still be the *most responsible physician* throughout the supervised period with full and direct responsibility for the decisions about patient care;
   - Are there local supports in place – Chief of Staff, Head of Department, etc.

3. Define the specific responsibilities for the supervisor (accountability for the supervisor).
   - Who does what, when to report.

4. Define the educational components that will connect with the supervision, if applicable.

The diagram below outlines the general degree of supervision inherent to different categories of physicians. Of course, the level of supervision within each of these groupings may be further modified according to additional issues associated with the subject physician's case.

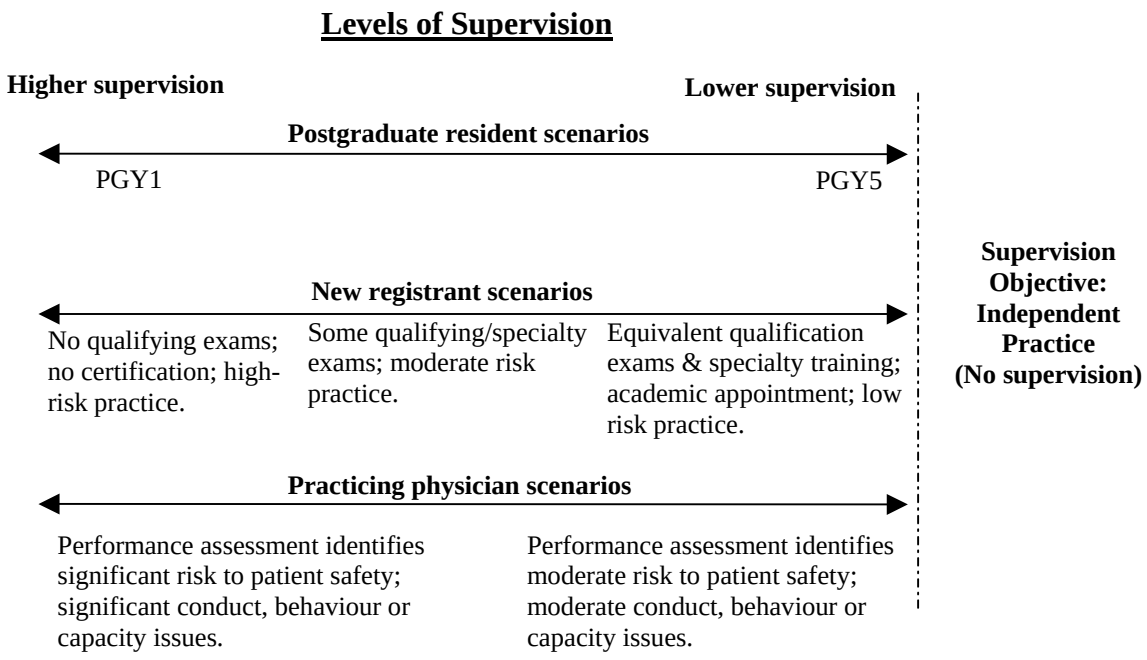


**Figure 1:** The diagram depicts the relative risk of different situations and relative levels of supervision deemed appropriate to ensure patient safety and quality care. There is a threshold beyond which the subject physician is competent to practice medicine independently (based on education, training, specialty certification, experience, current performance, and continuing professional development). Supervision is necessary until there is a demonstration of competence and performance.

The guidelines have been developed to apply to three different categories of supervised doctors:

- Part A - new registrants (International Medical Graduates, or IMGs);
- Part B - practicing physicians found to be experiencing problems with clinical performance or conduct;
- Part C - residents (postgraduate trainees).

# Part A – New Registrants to the College

In the situation of the newcomer to Ontario who is a well-trained physician from another country seeking licensure, the Registration Committee facilitates supervision under a restricted certificate of registration. The Registration Committee is empowered to exercise discretion about candidates whose training and clinical proficiency appear satisfactory, but who do not possess a specific credential as required by regulation.[1] Supervision is established to enable the applicant to practice in Ontario prior to full completion of all qualifications, that is, the Medical Council of Canada examinations and specialty certification by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC) or to enable him or her to demonstrate competence through practice experience and assessment. New registrants will not generally have a high degree of supervision, unless they are in a postgraduate training program. For most new registrants, the level of supervision will range from low to moderate.

**Considerations in establishing the nature of the supervision**

The questions set out below should be considered to establish the level of risk that would be associated with an unsupervised practice. The second stage of the analysis is to establish the level and nature of supervision required to reduce risk to a level in keeping with the provision of safe medical care. Components of a supervision program are described in Appendix 1.

**Risk Assessment**

**The applicant's situation**

- Does the candidate have more than five years experience practicing direct patient care in an independent and non-training environment?
- Is the candidate missing MCC QE1? QE2? RCPSC/CFPC? All of them?
- Is the candidate's scope of practice in Ontario comparable to his/her scope of practice in his/her preceding jurisdiction?
- Does the candidate have some or no experience in the Canadian context?

**Nature/Scope of practice**

- Does the applicant practice a specialty with potential for immediate and serious consequences to patient safety (surgery, anaesthesia, etc.)?
- Will the patient population be medical or surgical?
- Has the applicant arranged supervision by an acceptable supervisor in the desired community?
- Will the applicant practice in a remote, rural or urban situation?
- Will the applicant practice primarily in a (office-based) community, either solo or group?
- Will the applicant be accountable to others within an institutional framework (Head of Department, Chief of Staff, etc.)?

[1] In circumstances of uncertainty, the Registration Committee looks to registration policies and programs for assistance.

**Conclusion**

Committee judgement determines, through the answers about the applicant's situation and the nature and scope of practice, whether the level of supervision should be *low, moderate or high*. This conclusion is based on Committee members' experiences, public safety issues, risk assessment, and clinical judgement – there is no formula.

**Supervision program**

- What level of autonomy will the physician have? Is the physician the most responsible physician at all times? For a limited set of clinical procedures? Or is the physician in a clinical teaching setting full-time?

- How available must the supervisor be for the physician? Should the supervisor be available by phone only, or should the supervisor be in the practice location of the physician at all times?

- What components of supervision are essential? How many components are necessary and how frequently will each component be used? (See Appendix 1)

- Is an educational program to be an element of the supervision? Has there been a performance assessment to identify the educational objectives? Are these objectives clear to the physician?

- Are there other factors that confound the physician's performance, such as substance abuse or mental health issues, and if so, how are they being addressed?

- Who is responsible for the physician's educational advancement and how will this integrate with the supervision? How will the physician's time be allocated to prepare for examinations (such as the MCC or specialty certification) or a re-assessment?

- What will be the nature and frequency of the supervisor's reporting obligations to the College?

| | **Level of Supervision for New Registrants** | | |
|---|---|---|---|
| | Low | Moderate | High |
| Components of Supervision (see Appendix 1) | Medical record review, discussion with physician, some observation of performance. First month typically more frequent interaction. If performance found to be adequate, subsequent supervision components will be monthly. | Medical record review, discussion with physician, observation of performance, discussion with colleagues. Usually weekly or bi-weekly, gradually reduced to lesser frequency after one – three months of the program. | High level of supervision may be necessary for initial period; a specific set of procedures and associated decision-making may be directly observed. Usually such intensity would apply for up to one month, to determine if the physician can practice more independently in the long-term. |

| | Level of Supervision for New Registrants | | |
|---|---|---|---|
| | Low | Moderate | High |
| Availability of Supervisor | Physician can make decisions independently and remains the MRP. Supervisor is not required to be available on-site or immediately by phone; most supervision occurs within the context of regular reviews. Ideally, the supervisor will be part of the same group practice or in the same medical building. | Physician can make decisions independently and remains the MRP. Supervisor may be required to be available for the physician in case of patient consults. Most of the supervision occurs within the context of regular reviews. Typically, the supervisor will be in the same group practice or at a minimum, in the same medical building. | High level of supervision unlikely for new registrants, but if so, direct oversight of most patient care decisions. Supervisor will be on-site, or immediately available to the physician. |
| Autonomy of Physician | Physician is the MRP for all patient care decisions. Interaction with supervisor will generally be limited to guidance and support. | Physician is the MRP for all patient care decisions. Interaction with supervisor will include consultation on specific patient situations. | High level of supervision unlikely for new registrants, because applicants must be capable of practicing independently in most, if not all, situations. If, in an exceptional situation, a supervision program for a new registrant requires a high level of supervision, the physician is the MRP for all patient care decisions but may be in a clinical teaching unit with all of the responsibilities and parameters of a teaching program for residents. |
| Reporting to College | Typically reports will be made at about six month intervals. The supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients. | Typically reports will be made at two – four month intervals. The supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients. | Typically reports will be made at bi-monthly intervals, or more frequently, dependent on the practice circumstances. The supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients. |

| | Level of Supervision for New Registrants | | |
|---|---|---|---|
| | Low | Moderate | High |
| Education of Physician (in relation to supervision) | Physician will participate in professional development activities and prepare for remaining examinations. | Physician will participate in professional development activities and prepare for remaining examinations. | Physician will prepare for remaining examinations and may involve long-term educational goals, with additional training/practice experience commensurate with requirements for independent practice. |

**Examples of supervision structures**

In the examples below, there are differences that contribute to risk level and the associated increase in supervision level.

| **Example 1:** The doctor is a non-specialist who has practiced primary care outside of Ontario for 10 years. He has been deemed eligible to sit the examinations of the College of Family Physicians of Canada, and has completed his MCC QE1 (but not QE2). He plans to practice in a northern Ontario community in a group practice with a hospital close by. | |
|---|---|
| Practice experience: | Yes |
| Examinations missing: | MCC QE2; CFPC |
| Scope of practice: | Comparable to previous jurisdiction |
| Patient population: | Medical; primary care |
| Supervisor: | Yes; one of three practice partners |
| Region: | Rural |
| Type of practice: | Group practice; some institutional |
| **LEVEL OF SUPERVISION: LOW** | |
| Components of supervision: | Medical record review of 30 randomly selected records every two weeks in first month; monthly thereafter.<br>Meeting with physician every two weeks for first month; monthly thereafter. |
| Availability of supervisor: | Part of same group; usually available if needed outside of normal reviews. |
| Autonomy of physician: | MRP for all patient care decisions. |
| Reporting to College | Every six months. |

| | |
|---|---|
| **Example 2:** The doctor is a general surgeon who has practiced outside of Ontario for five years. He has been deemed eligible to sit the examinations of the Royal College of Physicians and Surgeons of Canada, but has not completed MCC QE1 or QE2. He plans to practice in a community hospital, just outside of a large urban centre. He will have privileges within the Department of Surgery at the local hospital, and will set up an office for consultations approximately 10 minutes away from the hospital. | |
| Practice experience: | Yes |
| Examinations missing: | MCC QE1; QE2; RCPSC |
| Scope of practice: | General surgery with some endoscopy; Ontario practice will be predominantly endoscopic. |
| Patient population: | Acute conditions, diagnostic and surgical |
| Supervisor: | Yes; member of hospital department |
| Region: | Urban |
| Type of practice: | Mostly institutional |
| **LEVEL OF SUPERVISION: MODERATE** | |
| Components of supervision: | Direct observation of three – five procedures per week for first month; direct observation of procedures about one-half day per month for next six months.<br>Medical record review in hospital and office of 10 randomly selected records (matched to hospital and office records for patients) every week for first month; every month thereafter.<br>Meeting with physician weekly to discuss cases for first month; then once monthly thereafter.<br>Interview of nurses, nurse manager, sample of colleague surgeons and referring doctors at the six-month point. |
| Availability of supervisor: | Within hospital department; available for telephone consultation, if necessary.<br>Roster of department members should also share in the indirect availability for the physician. |
| Autonomy of physician: | MRP for all patient care decisions. |
| Reporting to College: | Every six months, or more frequently if condition of agreement is breached or patient safety is at risk. |

# Part B – Practicing Physicians

College committees will set up physician supervision to address concerns about clinical performance. The expectation is to educationally address the identified deficiencies. Examples of such situations include a physician who has performed poorly on an assessment (such as PREP, SAP), a physician who has been found to require educational intervention, or a physician who is being monitored because of incapacity concerns or conduct issues, when clinical performance has been affected.

***Please note:*** These supervisory guidelines are meant to support situations where performance improvement is the goal. With physician health and conduct issues, the supervision may not always be consistent with these guidelines. In particular, these guidelines may not directly apply to case types in which the supervision is part of a process designed to seek sanctions on a physician's practice. For example, a physician with restrictions on his/her practice as a result of an interim suspension pending a disciplinary hearing, will include processes designed to ensure compliance, and there will be no attention given to the physician's education or improvement.

**Risk Assessment**

**The physician's situation**

- Why is supervision being organized – because of problems identified in a performance assessment, behaviour/conduct problems, capacity issues or otherwise?
- Is there a formal evaluation of the clinical performance concerns with specific areas of strength and development clearly identified?
- Is there a formal educational or behaviour modification program structured?
- Is there a history of clinical performance/conduct issues?
- How much experience does the physician have as an independent practitioner?

**Nature/Scope of practice**

- Is the physician's training and experience commensurate with his or her continued scope of practice?
- Has the physician been actively involved in his/her own continuous professional development?
- Does the physician have insight into his/her developmental needs and is he or she motivated to improve?
- Will the physician's continued practice pose immediate and serious risks to patient safety?
- Does the physician practice in a specialty with potential for immediate and serious consequences to patient safety (surgery, anaesthesia, etc.)?
- Is the patient population medical or surgical?
- Does the physician have a base of supportive colleagues and co-workers who are committed to his or her safe return to practice?
- Does the physician practice in a remote, rural or urban situation?
- Does the physician's continued practice provide regular interaction with colleagues who will form part of the formal and informal supervision structure (for example, community (office-based), either solo or group, institutional)?

## Conclusion

Committee judgement determines, through the answers about the physician's situation and the nature and scope of practice, whether the level of supervision should be *low, moderate or high*. This conclusion is based on Committee members' experiences, public safety issues, risk assessment, and clinical judgement – there is no formula.

## Supervision program

- Is there an educational program concomitant to the supervision? Has there been a performance assessment to identify the educational objectives? Are these objectives clear to the physician?

- Are there factors that confound the physician's performance, such as substance abuse or mental health issues, and if so, how are they being addressed?

- Is the physician's scope of practice clearly understood?

- Who is responsible for the physician's educational advancement (supervisor, someone else?) and how will this integrate with the supervision? How will the physician's time be allocated to prepare for a re-assessment?

- Is it necessary to identify another healthcare professional to serve as the supervisor?

- How available must the supervisor be for the physician? Should the supervisor be available by phone only, or should the supervisor be in the practice location of the physician at all times?

- What level of autonomy will the physician continue to have? Is the physician the most responsible physician at all times?

- What components of supervision are essential? How many components are necessary and how frequently will each component be used? (See Appendix 1)

- What will be the nature and frequency of the supervisor's reporting obligations to the College?

| | Level of Supervision for Practicing Physicians | | |
|---|---|---|---|
| | Low | Moderate | High |
| Components of Supervision (see Appendix 1) | ***Clinical Performance***<br>Medical record review, discussion with physician, possibly some observation of performance.<br>First month typically more frequent interaction. If performance found to be adequate, subsequent supervision components will be monthly.<br><br>***Capacity/Conduct***<br>Treating physicians and/or supervisor in position of authority (e.g., Chief of Staff) to set up system to monitor physician complaints from patients/staff, or systems to monitor treatment plans.<br>Possibly activities as above if clinical performance is an issue.<br>Monitoring to comply with available undertaking or Committee decision. | ***Clinical Performance***<br>Medical record review, discussion with physician, observation of performance, discussion with colleagues.<br>Usually weekly or bi-weekly, gradually reduced to lesser frequency after one – three months of the program.<br><br>***Capacity/Conduct***<br>Treating physicians and/or supervisor in position of authority (e.g., Chief of Staff) to set up system to monitor physician complaints from patients/staff, or systems to monitor treatment plans.<br>Possibly activities as above if clinical performance is an issue. Monitoring to comply with available undertaking or Committee decision. | ***Clinical Performance***<br>Medical record review for general and specific patient care decisions, discussion with physician, direct observation of performance and discussion with colleagues.<br>Direct oversight of any patient care interactions in which the patient may be at risk of harm (as specified in an undertaking). The direct oversight may be consultation on a patient-by-patient basis, or it may be a regular review of all interactions on a weekly basis. This level of supervision will continue until the Committee is satisfied that the level of supervision can be changed to moderate or low. The level of supervision required should be reviewed on a monthly basis.<br><br>***Capacity/Conduct***<br>Treating physicians and/or supervisor in position of authority (e.g., Chief of Staff) to set up system to monitor physician complaints from patients/staff, or systems to monitor treatment plans.<br>Possibly activities as above if clinical performance is an issue.<br>Monitoring to comply with available undertaking or Committee decision. |

| | Level of Supervision for Practicing Physicians | | |
|---|---|---|---|
| | Low | Moderate | High |
| Availability of Supervisor | Physician can make decisions independently and remains the MRP.<br>Supervisor is not required to be available on-site nor immediately by phone; most supervision occurs within the context of regular reviews.<br>Ideally, the supervisor will be part of the same group practice or in the same medical building.<br>In situations of capacity/conduct, supervisors must be in the community, and it may be necessary to seek another health care professional. | Physician can make decisions independently and remains the MRP.<br>Supervisor may be required to be available for the physician in case of patient consults. Most of the supervision occurs within the context of regular reviews.<br>Typically, the supervisor will be in the same group practice or at a minimum, in the same medical building. In situations of capacity/conduct, supervisors must be in the community, and it may be necessary to seek another health care professional. | Physician cannot make independent decisions, and as such, is likely only able to practice within a clinical teaching setting under the direct supervision of another physician.<br>Some areas of the physician's practice may be lower risk, and, accordingly, there may be situations in which the physician remains the MRP.<br>When physician is not the MRP, supervisor must be on-site and approve patient care decisions.<br>In situations of capacity/conduct, supervisors must be in the community, and it may be necessary to seek another health care professional. |
| Autonomy of Physician | Physician remains the MRP for all of his or her patient care decisions.<br>Interaction with supervisor will generally be limited to guidance and support, as defined by components of supervision. | Physician remains the MRP for all of his or her patient care decisions.<br>Interaction with supervisor will include more frequent consultation on specific patient situations. | Physician may not be the MRP for some or all of his or her patient care decisions.<br>Interaction with supervisor will be daily and the supervisor will be responsible for patient care decisions.<br>This is typical of a physician enrolled in a program in a clinical teaching unit with all of the responsibilities and parameters of a teaching program for residents.<br>For situations in which the physician is permitted to be the MRP, the moderate characteristics of supervision will apply. |

| | Level of Supervision for Practicing Physicians | | |
|---|---|---|---|
| | Low | Moderate | High |
| Reporting to College | ***Clinical Performance***<br>Typically reports will be made at about six month intervals with the caveat that the supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients.<br><br>***Capacity/Conduct***<br>Reporting will be dictated by the reasons leading to supervision, the level of concern about the physician and the treatment or behaviour modification plan in place. | ***Clinical Performance***<br>Typically reports will be made at two – four month intervals with the caveat that the supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients.<br><br>***Capacity/Conduct***<br>Reporting will be dictated by the reasons leading to supervision, the level of concern about the physician and the treatment or behaviour modification plan in place. | ***Clinical Performance***<br>Typically reports will be made monthly or bi-monthly, or more frequently, dependent on the practice circumstances. The supervisor must always report immediately if he or she believes that the physician has breached a condition of his/her supervision **or** there is immediate risk of harm to patients.<br><br>***Capacity/Conduct***<br>Reporting will be dictated by the reasons leading to supervision, the level of concern about the physician and the treatment or behaviour modification plan in place. |
| Education of Physician (in relation to supervision) | Typically self-directed learning, with guidance from the supervisor about how the education is being applied into practice. Supervisors do not usually take an active role in the physician's educational programs.<br>Education within a capacity/conduct issue will be determined by the nature of the concerns. | Typically self-directed learning and specified programs, with guidance from the supervisor about how the education is being applied into practice. Supervisors do not usually take an active role in the physician's educational programs.<br>Education within a capacity/conduct issue will be determined by the nature of the concerns. | Typically involves extensive remediation, the appointment of an educational preceptor, and regular attention to educational goals and progress reports, including integration with the supervisor's responsibilities. Supervisors do not usually take an active role in the physician's educational programs.<br>Education within a capacity/conduct issue will be determined by the nature of the concerns. |

**Examples of supervision structures**

In the examples below, there are differences that contribute to risk level and the associated increase in supervision level.

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| **Example 1:** The doctor is a non-specialist who has practiced primary care for 10 years. He is not a certificant of the College of Family Physicians of Canada. He has recently been assessed by the College's PREP evaluation, receiving a Category 4, moderate deficiency with educational plan and supervision required before re-assessment. | |
| Practice experience: | Yes |
| Evaluation completed: | Yes, clear delineation of areas needing improvement |
| Scope of practice: | Typical primary care |
| Patient population: | Medical; primary care |
| Region: | Rural |
| Continuous professional development: | Some, not structured, mostly journals and lectures |
| Type of practice: | Group practice; some institutional |
| **LEVEL OF SUPERVISION: LOW** | |
| Components of supervision: | Medical record review of 30 randomly selected records every two weeks in first month; monthly thereafter.<br>Meeting with physician every two weeks for first month; monthly thereafter. |
| Availability of supervisor: | Family/general physician in community; usually available if needed outside of normal reviews; group partners also available regularly. |
| Autonomy of physician: | MRP for all patient care decisions. |
| Reporting to College: | Every six months. |
| Educational program: | Yes, as determined by Committee, physician. |

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| **Example 2:** The doctor is a general internist with more than 15 years experience. He is practicing in community hospital, just outside of a large urban center. He has privileges within the Department of Medicine at the local hospital, and has an office for consultations approximately 10 minutes away from the hospital. He is being treated for substance abuse, and there has been some concern about his clinical performance, although there has not yet been an evaluation and it is likely that his clinical performance has been affected by his dependency. | |
| Practice experience: | Yes |
| Evaluation completed: | Treated for substance abuse; no formal performance evaluation, but identified with clinical concerns during the course of a medical inspection |

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|---|---|
| Scope of practice: | General internal medicine; on-call coverage for emergency department; office consultations and follow-up |
| Patient population: | Acute and chronic medical conditions |
| Supervisor: | Yes; member of hospital department |
| Region: | Urban |
| Type of practice: | Institutional and community-based |
| **LEVEL OF SUPERVISION: MODERATE** | |
| Components of supervision: | ***Capacity:***<br>Ongoing treatment plan through the Physician Health Program includes treating psychiatrist, counsellor, and family physician, as well as a workplace monitor in the hospital. The workplace monitor (supervisor) is responsible for the doctor's continued compliance with his treatment program and undertaking to the College.<br>***Clinical Performance:***<br>Medical record review in hospital and office of 10 randomly selected records (matched to hospital and office records for patients) every week for first month; every month thereafter.<br>Meeting with physician weekly to discuss cases for first month; then once monthly thereafter.<br>Direct observation of three – five patient encounters in emergency consultations and office every two weeks for first month; direct observation reduced to one-half day per month for next six months.<br>Interview of nurses, nurse manager, sample of colleagues and referring doctors at the six-month point. |
| Availability of supervisor: | Within hospital department; available for telephone consultation if necessary.<br>Roster of department members should also share in the indirect availability for the physician. |
| Autonomy of physician: | MRP for all patient care decisions. |
| Reporting to College: | Every six months, or more frequently if condition of agreement is breached or patient safety is at risk. |

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| **Example 3:** The doctor is a general surgeon who has been assessed as a Category 5 on a Specialties Assessment Program (serious deficiencies, not able to practice without direct supervision and remedial program). He is motivated to improve, he appreciates the degree of improvement required and has been accepted to a clinical teaching setting for a period of six months. He will have privileges within the Department of Surgery at the local hospital, and will set up an office for consultations approximately 10 minutes away from the hospital. | |
| Practice experience: | Yes |
| Evaluation completed: | Yes, clear delineation of areas needing improvement |
| Scope of practice: | General surgery with emphasis on endoscopy |
| Patient population: | Acute conditions, diagnostic and surgical |
| Continuous professional development: | Yes; member of hospital department |
| Region: | Urban |
| Type of practice: | Mostly institutional |
| **LEVEL OF SUPERVISION: HIGH** | |
| Components of supervision: | Direct supervision as provided for residents in training, for at least six months. Full-time enrollment in educational program. Supervision subject to change only after full evaluation by clinical teaching unit and approval by Committee with appropriate community supervision in place. |
| Availability of supervisor: | Direct; clinical teaching unit. |
| Autonomy of physician: | Not the MRP for at least six months. |
| Reporting to College: | End of six months, or more frequently if condition of agreement is breached or patient safety is at risk. |

# Part C – Residents in Postgraduate Programs

For residents, supervision is a responsibility of the medical schools and its postgraduate training programs. Supervision is an integrated part of the resident's training and education, and it is designed to ensure - whether in a teaching hospital or community environment - that patient safety is the first priority. In this supervision context, residents are permitted to perform patient care through delegation on a graduated basis, with independence commensurate with the resident's program level, area of specialty training, and individual capabilities. The objective is for each resident to satisfactorily complete his or her training, qualifying and specialty certification examinations.

*The College is not responsible for establishing or maintaining resident supervision programs*. This section has been developed to augment the College's *Professional Responsibilities in Postgraduate Medical Education* policy and the Council of Ontario Faculties of Medicine's *Principles Re: Supervision of Postgraduate Medical Trainees (November 2003),* and to assist the medical schools in understanding the applicability of the policy.

**The resident's situation**

The resident situation will depend on the medical school, the program, the year of training and other circumstances considered relevant by the postgraduate training program.

**Nature/Scope of practice**

- What program year is the resident in; level 1 – 5 or clinical fellow?
- Is the resident in a specialty program in which there may be immediate and serious consequences to patient safety (surgery, anaesthesia, etc.)?
- Is there the potential for procedures, treatments or otherwise, performed by the resident, to be immediately risky to the patient's safety?
- Is the resident in a teaching institution or a community-based practice?

**Conclusion**

The Postgraduate Departments and their Programs will determine the level of supervision. The College supports these determinations and has tried to provide a consistent framework for use by the medical schools.

**Supervision program**

- Has there been a performance assessment to identify the educational objectives? Are these objectives clear to the resident?
- Are there other factors that may confound the resident's performance, such as substance abuse or mental health issues, and if so, how are they being addressed?
- Is the resident's scope of practice clearly understood? Who is responsible for the resident's educational advancement and how will this integrate with the supervision? How will the resident's time be allocated to prepare for examinations, such as the MCC or specialty certification exams?

- How available must the supervisor be for the physician? Should the supervisor be available by phone only, or should the supervisor be in the institution? Directly in the unit/OR?
- What level of autonomy will the resident have?
- What components of supervision are essential? How many components are necessary and how frequently will each component be used? (See Appendix 1)

| | Level of Supervision for Residents | | |
|---|---|---|---|
| | Low | Moderate | High |
| Availability of Supervisor | Supervisor is available to the resident, by telephone, within the institution or on call for immediate attendance. Practices will be determined by the medical school and institution. | Supervisor is available to the resident, by telephone, within the institution or on call for immediate attendance. Practices will be determined by the medical school and institution. | Supervisor is available to the resident, by telephone, within the institution or on call for immediate attendance. Practices will be determined by the medical school and institution. |
| Autonomy of Resident | Resident is not the MRP.<br><br>Residents who are close to completing their program and achieving independent practice status may exercise independent judgement in a variety of situations that would not require direct approval by the supervisor. | Resident is not the MRP.<br><br>For some residents, there may be some situations in which they act independently with minimal interaction with the supervisor (e.g., low-risk procedures, treatments, patient examinations). | Resident is not the MRP.<br><br>These residents require direct and immediate supervision, and their independence is limited or non-existent. |
| Education of Resident (in relation to supervision) | Educational component is always inherent to the environment. | Educational component is always inherent to the environment. | Educational component is always inherent to the environment. |

**Examples of supervision situations**

The following are examples provided for the purpose of this document by the Postgraduate Education Committee of the Council of Ontario Faculties of Medicine. Consider the circumstances described for varying levels of training. Within each example, there are numerous supervisory questions, which could be raised. The resident's training and experience and other situational factors will contribute to the risk level and the associated change in the level of supervision.

**Example 1 (low acuity):** The diagnosis of appendicitis is made in an 18-year-old male at 2 a.m. Appendectomy is indicated and the operating room will be available in one hour. (The assumption in each case is that the consultant is the MRP and has confidence in the abilities of the resident in the tasks assigned).

- What level is the resident (PGY1, 2, 3, 4, 5+)?
- When does the consultant need to be notified (pre-operatively? In the morning?)?
- What is adequate supervision? (consultant scrubs, consultant present in OR but does not scrub, consultant in hospital but remains in office, consultant directs resident to proceed but remains at home)
- What if an unexpected finding is discovered at laparotomy (e.g., Meckle's Diverticulum) and resection is thought appropriate? When should the consultant be notified (prior to intervention, end of case, in the morning)?

**Example 2 (high acuity):** A resident in orthopaedic surgery is to perform an elective total hip replacement. The resident has participated in a number of these procedures previously. (The assumption in each case is that the consultant is the MRP and has confidence in the abilities of the resident in the tasks assigned).

- What is the level of the resident (PGY1, 2, 3, 4, 5+)?
- What would be considered appropriate consultant supervision – consultant in the OR scrubbed, consultant in the OR suite but not scrubbed, consultant in the hospital but not in the OR suite, consultant out of the hospital?
- The resident has difficulty achieving the correct alignment of the components of the prosthesis and requests help. How should the consultant be available – in the room five or 10 minutes, available to be in the room in 10 minutes, phone advice only?

# Effective Accountability for Supervisors

| | |
|---|---|
| ***Documentation of supervision***<br><br>• Supervision is a significant responsibility – documentation is critical;<br>• Supervision reports might be used for other purposes, and the author should always prepare reports with this in mind;<br>• Supervisors should always maintain complete documentation to support their reports;<br>• At the conclusion of the supervision (or if the supervisor relinquishes his or her responsibilities), it is advisable for the supervisor to retain his or her notes or send them to the College for retention. | ***College Agreements with Physicians and Supervisors***<br><br>An effective agreement will outline:<br>• The specific components of supervision and the frequency of their application (e.g., medical records will be reviewed every week);<br>• The frequency of reporting obligations to the College;<br>• The supervisor's responsibilities if the physician breaches a term of his or her agreement or if patients are at risk;<br>• Contingencies if the supervisor is unable to fulfill his/her responsibilities;<br>• Remuneration issues, if any, for the supervisor. |
| **Report Writing by Supervisors**<br><br>An effective and useful report will:<br>• Be concise; address specific needs of the College;<br>• Be provided on time according to the agreement;<br>• Refer to the specific reporting period in question (week of…, month of…);<br>• Describe the nature of interactions in referenced period (reviewed medical records, talked to Dr. X, etc.);<br>• List areas of strengths and areas in which improvement is necessary;<br>• Support statements with facts (from patient records, direct observation, etc.);<br>• Outline specific objectives or actions expected of the physician for next reporting period;<br>• Provide overall impressions about physician's progress, response to education and supervision (e.g., Did physician show up for scheduled meetings?) include for example current diagnostics/therapeutics, examinations, problem formulation, communication and interviewing skills, record-keeping, technical skills;<br>• Refrain from using inflammatory or gratuitous language;<br>• Provide a reasonable, fair, objective opinion based on circumstances. | **Liability of Supervisors**<br><br>• *Under review*, in context of all "experts" who are retained by the College;<br>• General directions will be provided to physicians who agree to assume these responsibilities. |

# Appendix 1
# Components/Tools of Supervision

The effectiveness of supervision programs will be directly related to the components of supervision selected and their frequency of use. The components outlined below can be used in combination in any type of supervision program.

1. Discussion with Physician (Collegial Peer Review)
    - Direct and as unstructured or structured as situation requires (i.e., low level supervision based on unsatisfactory performance on PREP may consist of a monthly meeting; high level supervision based on doctor's past inappropriate behaviour toward colleagues may consist of a series of structured questions);
    - Supervisor and physician remain in direct contact, maintaining regular communication with each other;
    - Must be regular as defined by situation, but to be effective, no less than once per week in person or by phone.

2. Self-Evaluation
    - Would not be used exclusively;
    - Practice reflection tools (physician questionnaire in peer assessment, facility risk assessment for office-based practitioners) - can help guide physicians through a reflective exercise.

3. Medical Record Review
    - Medical record review protocols from the College (e.g., peer assessment) are available to structure and direct the review;
    - Uses direct patient examples from the medical records to show strengths and weaknesses;
    - Medical record review can help the supervisor understand many aspects of physician's knowledge, skill and patient care decision-making (examinations, differential diagnosis, diagnosis, history and functional inquiry, treatment plans, drug selection, etc.).

4. Review of Practice Data
    - Not common, based on inconsistent availability of data for physicians;
    - Practice data for an individual physician and/or department, may be available on a regular or ad hoc basis, dependent on the facility;
    - This data may augment, but must be used in conjunction with, other assessment components.

5. Direct Observation
    - Observing all aspects of patient care for assessment, examination, history-taking, ability to arrive at differential diagnosis, treatment and therapy, pre-operative, operative management skills (technical), post-operative management, communication skills;
    - Can take the form of person-to-person or distant observation (the NORTH Network allows for distant consultations between physicians; web-based OSCE's are in use in some US medical schools to evaluate students through broad band connections) – this is a very important consideration for physicians with restricted certificates of registration practicing in remote areas with few opportunities for

face-to-face interaction with a supervisor, or when one physician is the only specialist in town;
- Predominantly forms part of moderate and high levels of supervision; may be low level in some cases;
- Quality Management Division is currently exploring use of distance observation through its Registration Through Practice Assessment program.

6. Interviewing Colleagues
   - A broad spectrum of colleagues and team members who work closely with the physician and who will observe, over a period of time, his/her technical skills, patient and colleague communication skills, judgement and practice management issues;
   - The anonymity of interviewees must be secured in any report; but interviewees should be as candid as possible;
   - A list of structured questions can assist in the interview and help the supervisor to probe certain issues.

7. Peer/Colleague/Patient surveys
   - Not yet common, but growing availability of valid and reliable survey instruments will allow it to be used more frequently in the future;
   - Used to evaluate skills that are not easy to evaluate with other techniques (humanistic and professionalism components) and to receive patient input;
   - The College of Physicians and Surgeons of Alberta uses surveys as part of their assessment process, and have loaned components of their surveys to Ontario for the Registration Through Practice Assessment program.

8. Standardized patients
   - Laypersons trained to portray patients in clinical encounters and to record as well as observe physician/student behaviours using standardized protocols;
   - Not common yet in College assessments;
   - Can control the type of encounter and direct the evaluation towards certain skills.