Clinical Supervision Support Program

A/Prof Liz Molloy

Monash University, 2012

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HealthWorkforce AUSTRALIA

An Australian Government Initiative

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Project Partners:

Alfred Health, Cabrini Health, Central Bayside Community Health Services, Department of General Practice Monash University, ERMHA, La Trobe University, Monash Division of General Practice, Monash University, Queen Elizabeth Centre, St John of God Health Care

Educators/Educational Researchers:

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Professor David Boud
Dr Geoff White
Dr Clare Delany
Ms Debra Kiegaldie
Dr Margaret Bearman
Dr Megan Dalton

Workshop Objectives

By the end of today's workshop, participants will be able to:

- Describe what is meant by clinical supervision including associated roles, responsibilities and behaviours
- Reflect on their own strengths, deficits and learning needs as a clinical supervisor
- Identify how students learn by drawing on key educational theories and research

Workshop Objectives…

- Discuss ways to facilitate student learning including scaffolding for increasing independence
- Identify key components for effective feedback and clinical assessment
- Recognise underperforming students and effective management strategies

But wait, there's more…

Online Interactive Support

1) Equivalent workshop developed as an online package http://clinicalsupervisionsupport.org (as an alternative, or complement, to face-to-face workshop)

2) Profession-specific clinical supervision modules with a focus on context-specific educational issues, supervisory models and modes of clinical assessment

3) Ongoing Support: expert-mediated online clinical supervisor support forum

NB No cost to participants

One-off educational initiatives…

aren't much…

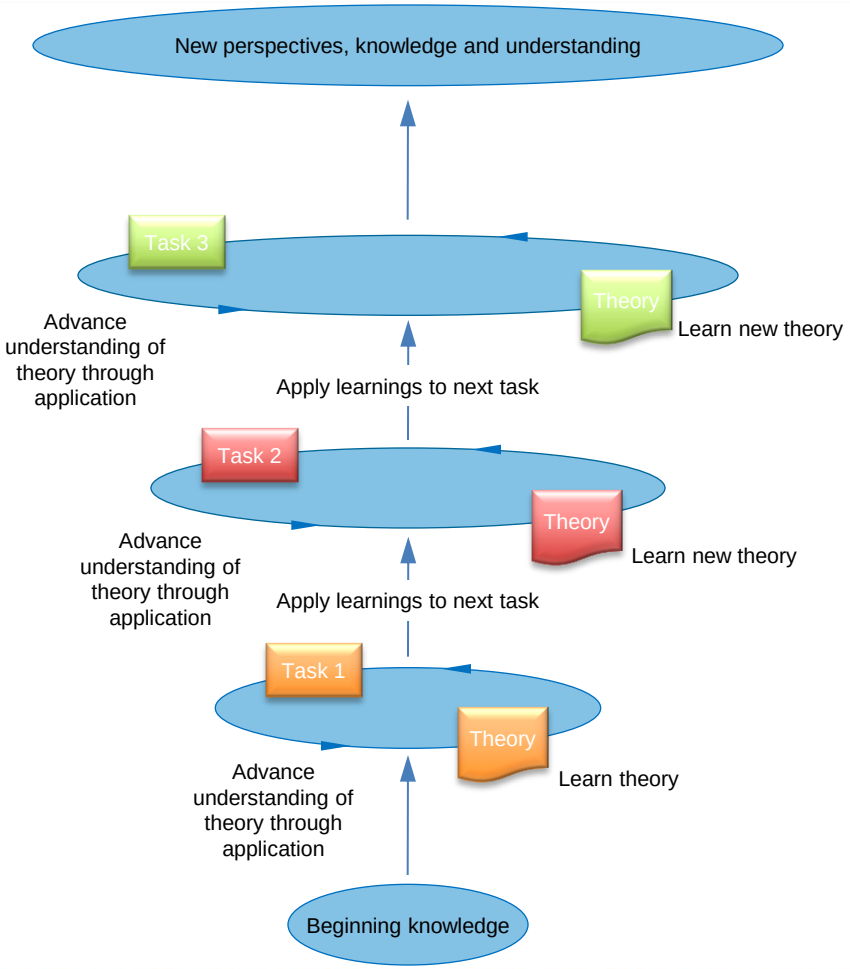
Masmanian & Davis (2002)

Our goal is to provide ongoing support and to build an Educational Community of Practice throughout Victoria

In contrast to the *“here’s some theory, best of luck”* model

Iterative Model of Learning

Delany and Molloy (2009)



Introductions

What is your background in clinical supervision?

What would you particularly like to get out of this session?

Clinical *educators* want more *education* on *education*

Neville and French (1991)

Kilminster and Jolly (2000)

Harden and Crosby (2000)

Molloy (2009)

Higgs and McAllister (2006)

Activity 1

How might your skills as a clinician translate to effective teaching skills?

Clinical skills:
Do they help or hinder education skills?

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Potential advantages

Strengths in observation

Diagnosis and treatment

'Helping' culture

Communication

Patient education (explaining diagnosis, teaching motor skills, feedback, etc.)

Potential disadvantages

Taking control of diagnosis and 'fixing'

Responsibility for outcomes (boundaries)

Doers/Culture of Immersion: "*the more you do, the better you'll be*" vs. *structured reflection*

Educating Educators

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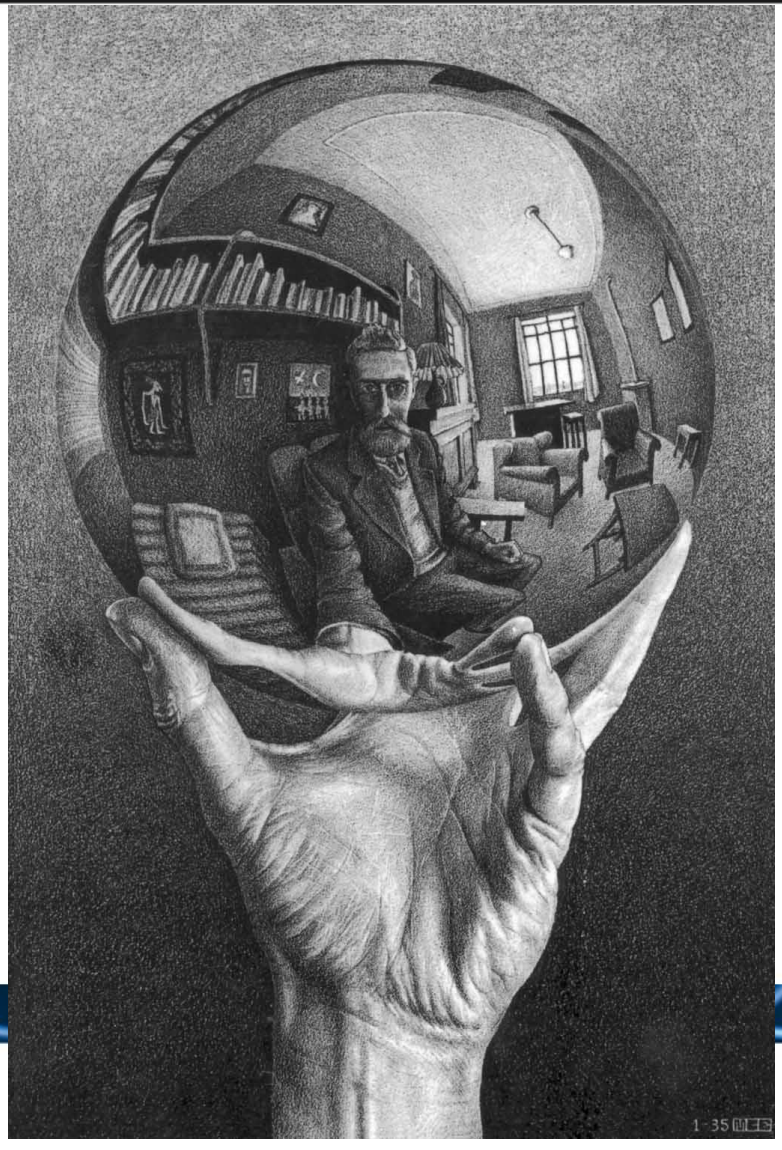
How?

1. Drawing on educational community of practice (sharing collective wisdom – e.g. online “Clinical Supervision Portal” and the tea room)
2. Evidence from educational research: What works?
3. Theories of teaching and learning:
   e.g. Adult Learning, Experiential Learning, Reflection

Time to reflect...



Activity 2: Reflect on your experience of clinical supervision

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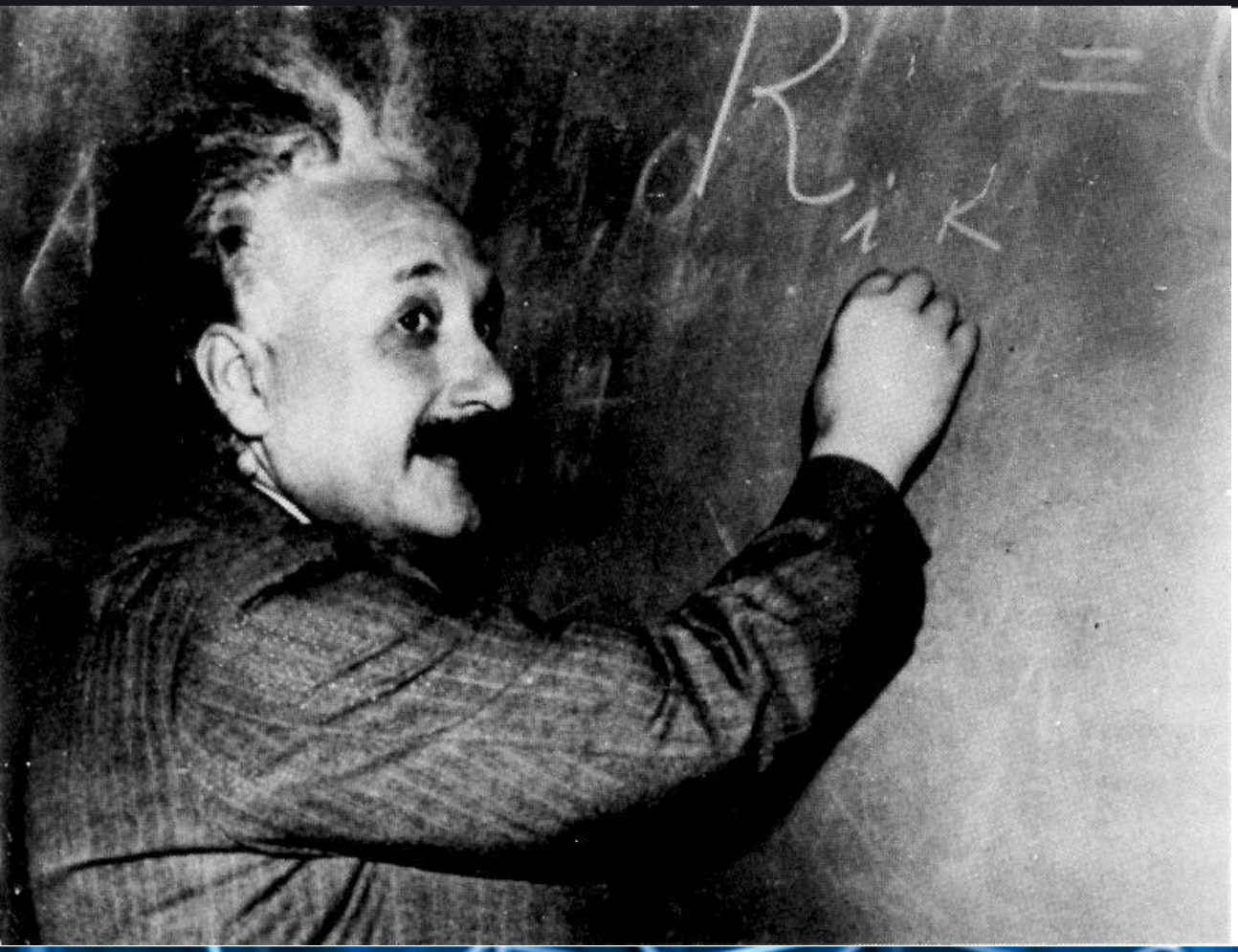
What works well in clinical supervision?

What doesn't work so well?

A tiny bit of educational theory



Clinical supervision is a little bit about *training* and a lot about *education*

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Training:

Learning process with known outcomes

Repetitive skills and uniform performances

Education:

Deals with unknowns

Requires complex synthesis of knowledge, skills and experience

Kilminster (2009) and Higgs (2009)

A tiny bit of educational theory

1. Adult Learning
2. Critical Reflection
3. Experiential Learning

1. Adult Learning

"The learner is active in co-producing knowledge, rather than framed as a recipient of knowledge."

Molloy and Boud (2012) in press

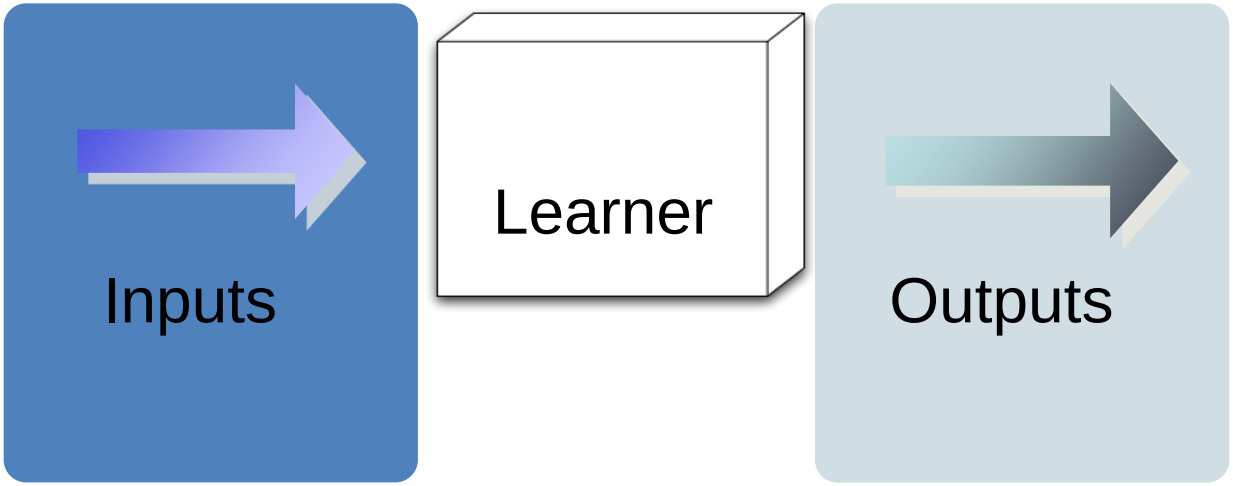
Much of adult learning theory has sprung from Constructivism

e.g. Biggs 1993, Price 2010

Constructivism v.s. Behaviourism

Constructivism considers the learner's role – as opposed to Behaviourism

e.g. Skinner 1950s, Bandura 1970s



Principles of adult learning

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Dependent learners:

Rely on adults to teach

Independent learners:

Set their own learning agenda

Autonomous learners:

Recognize their own learning style
Actively reflect on learning experiences
Show initiative & motivation to contribute to learning agenda

Dependent / Independent learning spectrum

“ It is helpful to remember that what the student does is more important in determining what is learned than what the teacher does. ”

Sheull in Biggs 1993 p. 73.

2. Critical Reflection

Indulgence under the willow tree?

What is reflection?

Reflection is a human activity in which people recapture their experience, think about it, mull it over and evaluate it.

It is this working with *experience* that is important in learning.

Critical Reflection

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Critical reflection is a process that…

- Enables analysis of knowledge
- Provides a framework for changing and developing knowledge
- Makes educators' and students' knowledge more transparent
- Is a key skill for professional work as a health practitioner

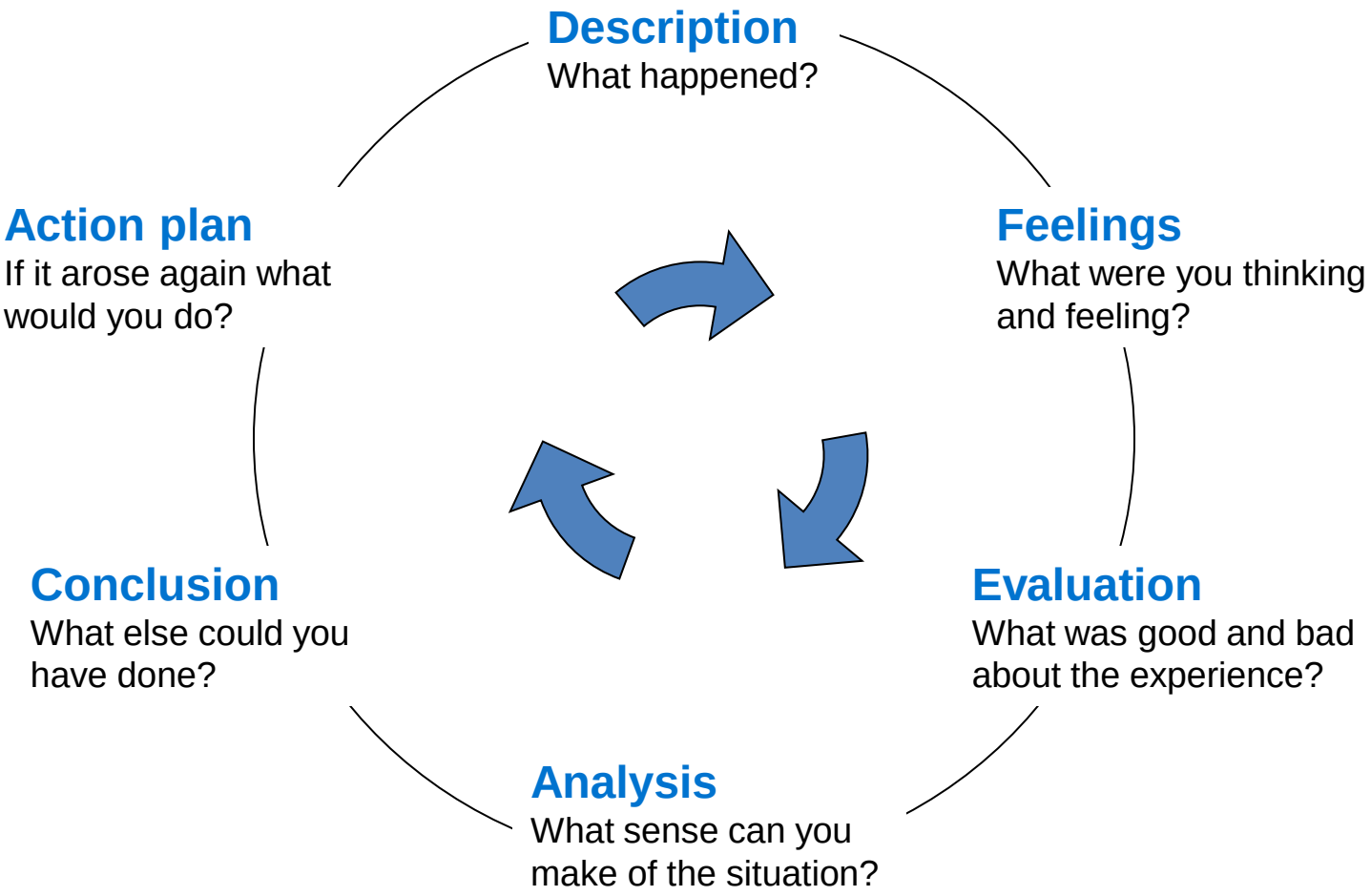
What is reflective practice?

Reflection-in-action: the ability of a practitioner to 'think/act on their feet'

Reflection-on-action: after an experience a practitioner analyses their reaction to the situation and explores reasons around, and the consequences of, their actions

Schon (1987)

Reflection on action



(Gibbs, 1986)

Reflection involves discrepancies & dissatisfactions

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A state of perplexity, hesitation, doubt

(Dewey 1933)

Inner discomforts

(Brookfield 1987)

Disorienting dilemmas

(Mezirow 1990)

If things are going swimmingly...

…why waste the cognitive effort ?

Why do we want students to be reflective?

It helps equip students to learn from messy practice

The swampy lowlands of messy practice v.s. the high plains of technical rationality (Schon 1987)

It helps to harvest students' capacity for evaluative judgement *(How did I perform in relation to the expected standard? How is my supervisor working with patients? Do I want to take on those approaches in my practice?)*

3. Experiential Learning (Kolb, Dewey, Piaget)

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- applied knowledge
- '*on-the-job*' learning
- self-initiated
- evaluated by the learner
- more likely to have a long term effect on the learner

Experiential Learning
Kolb's Learning Cycle

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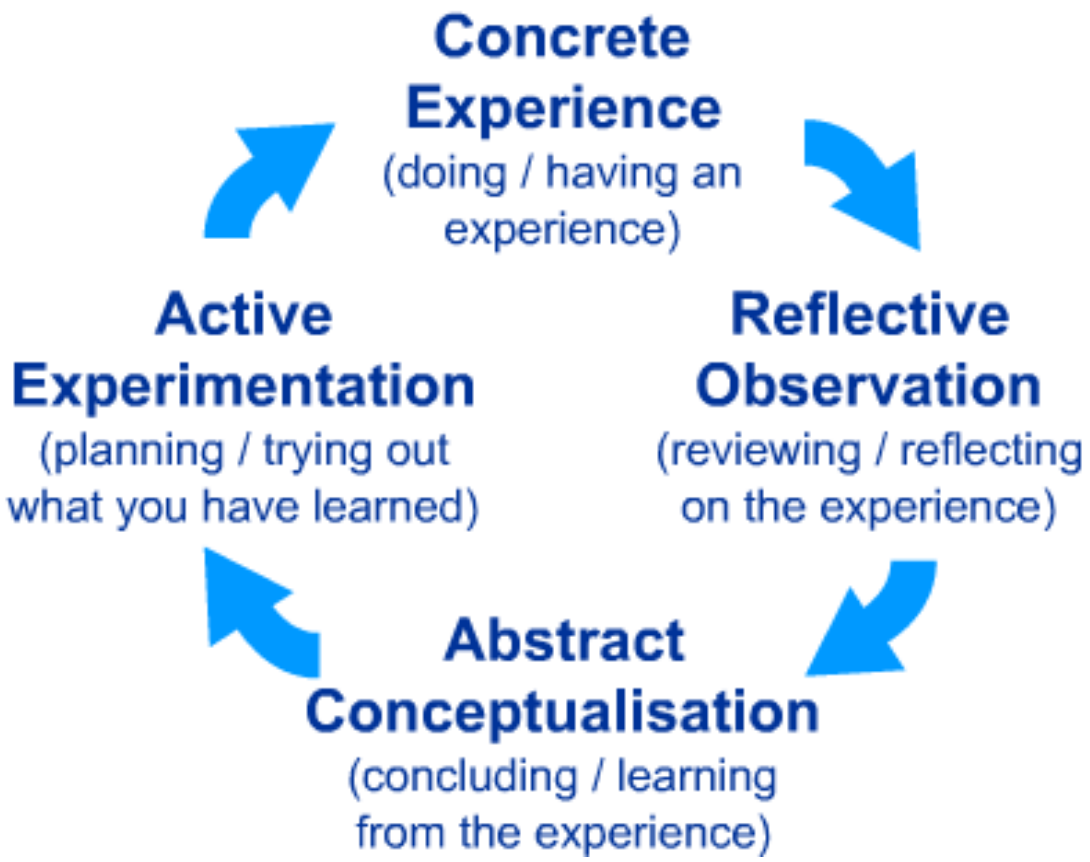

(Davies & Lowe, Uni of Leeds, 2006)

Supervisory Models

Supervision

Mentoring

Others:

- Preceptorship
- Coaching
- Patients as teachers
- Peers as teachers
- Role modelling

Mentoring: Reciprocity, Trust and Development of Mentee

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"An enabling relationship that facilitates another's personal growth and development. The relationship is dynamic, reciprocal and can be emotionally intense. Within such a relationship the mentor assists with career development and guides the mentee through the organisational, social and political networks."

(Morton-Cooper & Palmer, 2000)

Supervision: formality and assessment

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"An exchange between practicing professionals to enable development of professional skills."

(Butterworth 1992)

"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, Cottrell, Grant & Jolly, 2007)

Mentorship and Supervision

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	Mentorship	Supervision
Focus	Profession/career (stimulate, guide, reflect)	Skills/clinical/placement (demonstrate, monitor, assess)
Driver	Internal (driven by the needs of mentee which in turn drives the roles and boundaries of the partnership)	External (driven by the needs of the student to attain competence)
Participation	Voluntary (mentor and mentee have choice to participate in mentoring and mentoring process)	Mandatory (may be required part of a formal or structured education, registration or credentialing process)
Communication	Face-to-face or distance	Face-to-face
Duration	Longer or shorter term (may extend over a number of years or be limited by the needs of mentee)	Shorter term (normally limited to the duration of the placement or related activity)
Choice	Choice of mentor	Assigned preceptor/supervisor
Assessment & Competence	No supervision or assessment Involved (dynamics of partnership are destroyed if assessment involved)	Supervision and assessment may be Involved

Supervisory Models
(supervisor : student ratios)

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Great variability amongst the professions

Range 1:1 to 1:12

Range within the room today?

Impact on supervisor load, impact on learner, economical impact, impact on the role of peers in clinical education

Lekkas, P, Larsen, T, Kumar, S, Grimmer, K, Nyland, L, Chipchase, L, et al. (2007)

Workforce changes and likely impact on supervisory models

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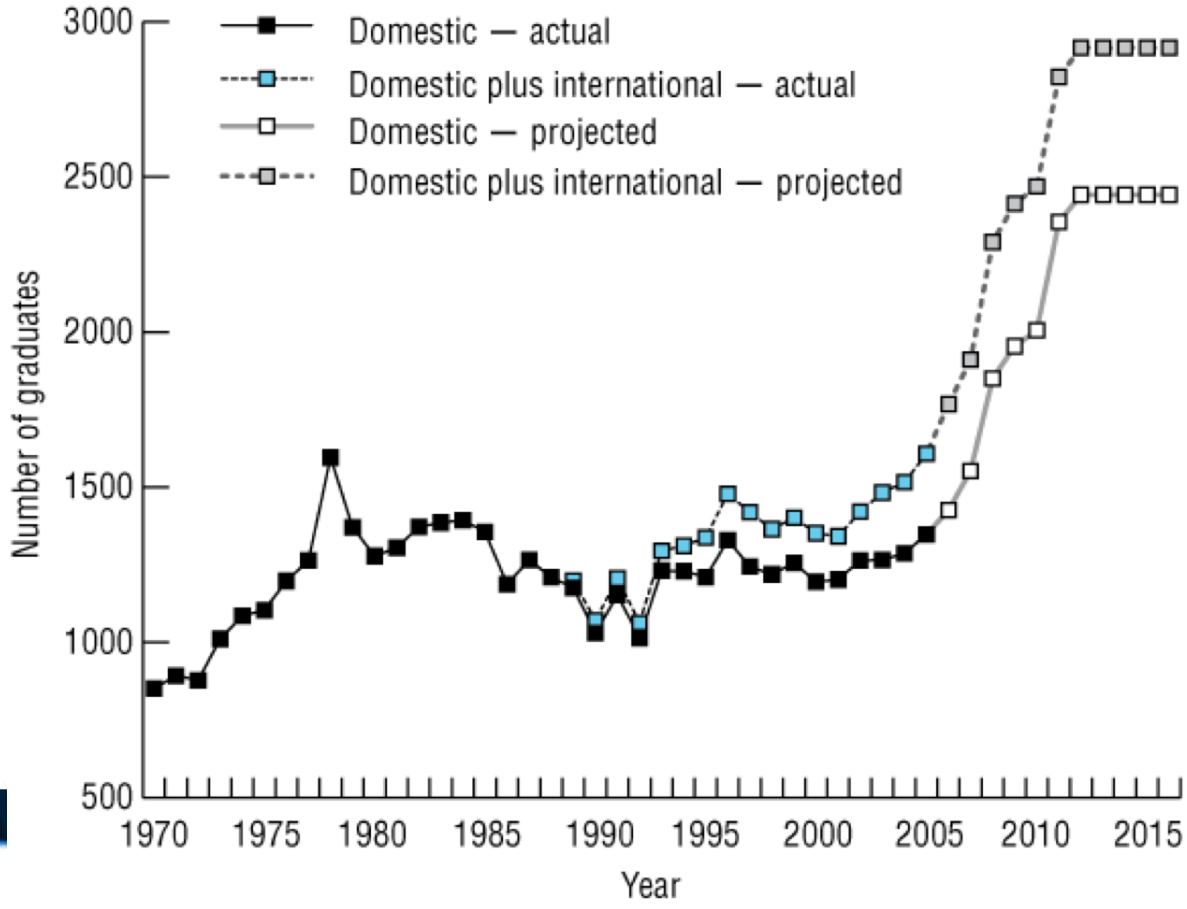
Australian university medical school graduates actual and projected, 1970–2016[10].



Workforce changes and likely impact on supervisory models

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Changing ratios in Clinical Supervisory Models

Expanding fieldwork opportunities ie community based practice

Expanding stakeholders in the ‘education of students’ ie the role of patients and peers in feedback

Expanding teaching and learning methodologies ie simulation

Roles of Clinical Supervisor

A balancing act

Roles of Clinical Supervisor

- ✓ Manager
- ✓ Observer
- ✓ Feedback
- ✓ Instructor
- ✓ Counsellor
- ✓ Assessor

Best & Rose (2005) *Transforming Practice through Clinical Education Professional Supervision and Mentoring*

Roles of Clinical Supervisor

- ✓ Information provider
- ✓ Role model
- ✓ Facilitator
- ✓ Assessor
- ✓ Curriculum and course planner
- ✓ Resource material creator

Harden & Crosby (2000)

How can we measure clinical supervisors' ability?

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Multisource feedback tool

Maastricht Clinical Teaching Questionnaire (MCTQ)

(Stalmeijer 2008)

Construct Validity: Three groups of stakeholders – educationalists, clinical supervisors & students

(Stalmeijer 2008)

Reliability: Supervisor self-rating and student rating. Minimum of **six** responses to ensure reliable ratings.

Stalmeijer et al (2010) based on Dolmans and Ginns (2005)

Activity 3: Your own self-assessment of clinical supervision practice

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Using the MCTQ

Break for mind body refreshment

Tensions in clinical supervision

Patient Well-being

Student Learning

Tensions in clinical supervision

Clinician as Mentor

Clinician as Assessor

Tensions in clinical supervision

Patient Safety

Student Autonomy

Clinical Supervisor Responsibilities

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Provide quality patient care

Provide ‘good’ supervision to all their students...

- Some view ensuring students ‘pass’ as a proxy for effective supervision

Ensure protection of professional standards

Research suggests that supervising poorly performing students exacerbates the competition between these responsibilities

Bearman, Molloy, Keating and Ajjawi (2012 in press)

Effective Supervisors

Direct clinical guidance

Joint problem solving

Linking theory to practice

Timely feedback

Reassurance

Role modelling

Clear goals and orientation

Good teaching skills

Higgs 2004, Delany and Molloy 2009

Good interpersonal skills

Demonstrate Competence

Use valid assessment methods

Focus on key concepts not intricate details

Learn from students

Facilitate active learning

Encourage student independence

Positive

The Ineffective Clinical Supervisor

Preparing Students for Practice

Preparing Students for Practice

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What educators and supervisors do:

- *Before*
- *During*
- *After*

Makes a significant difference to students' learning and comfort

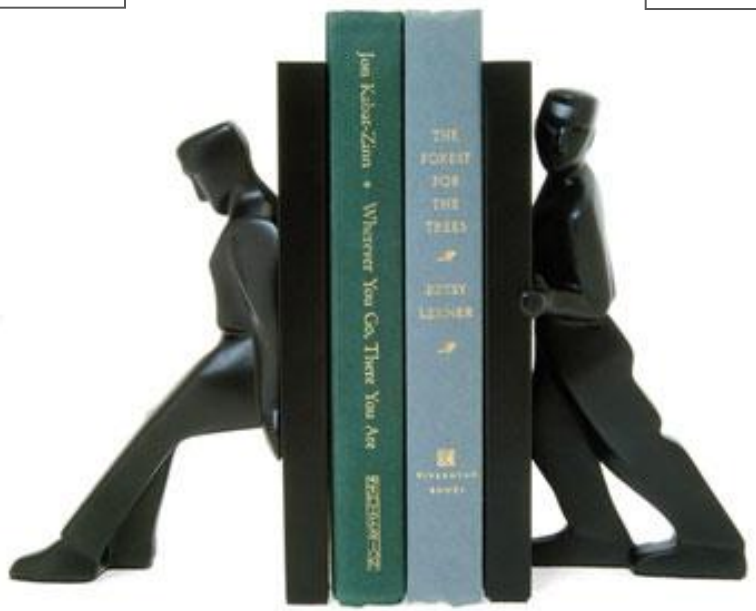
(Molloy and Keating 2011)

Often ‘the brief’ is all too brief

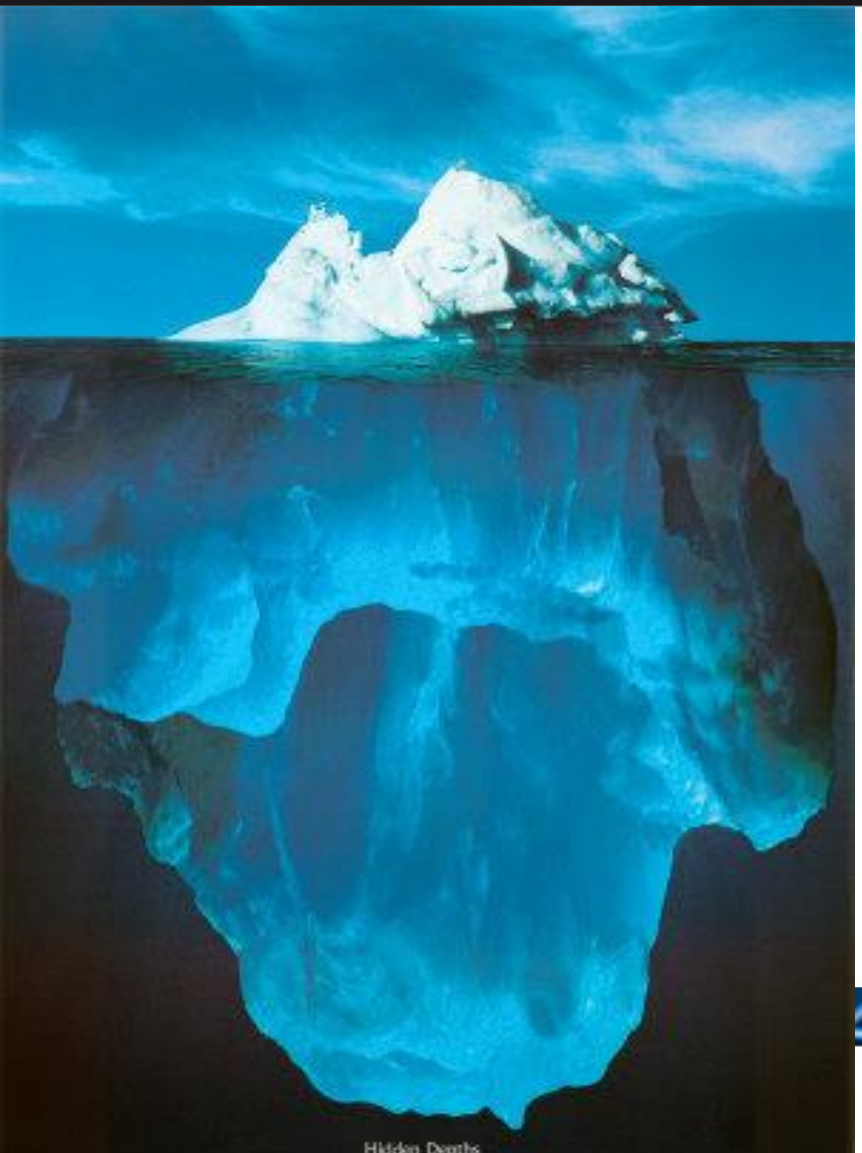
Brief

Do

Debrief



Transition Programs and Clinical Supervisors



Help expose the “hidden curriculum” through explicit teaching and informal conversations

Practices, skills, knowledge, values, institutional norms, relationships that we take for granted as clinicians

Students reflections on clinical education in 2007

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Survival tips for students about to enter clinical education

- 'Play the game' (pick up on the expectations of clinical educator and the institution)
- Be prepared for hard work
- Assertive in patient interviews
- Time management is vital-plan your day
- Know the multidisciplinary team members
- Be you, and use your knowledge (try not to get overwhelmed with assessment and supervision process)
- Ask questions
- Seek and use feedback during clinical education blocks

First Clinical Experiences

Undergraduate physiotherapy students consistently report that they feel under prepared for the complexity and uncertainty of clinical practice.

(Molloy and Clarke 2005)

True for other Health Professions

(Ansari 2003; Neville and French 1991; Cupit 1988)

First Clinical Experiences

“ We all know in theory what it should be like, but it will be very different in real life…”

Student 1 Molloy and Keating (2011)

The stakes are higher

“ The sort of practice that we do here seems to be insignificant compared to what we’re going to be doing because like she said, it’s like, I know Tom [student], I don’t care if he falls.”

Student 2 Molloy and Keating (2011)

Anxiety about level of competence: Will I be any good?

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“ *I’ll open my mouth and they will know that I am not competent* ” Student 4

Dual audience: both supervisor and patient

Students don’t use exam marks or OSCE results as surrogates for likely performance in clinical practice.

Scaffolding

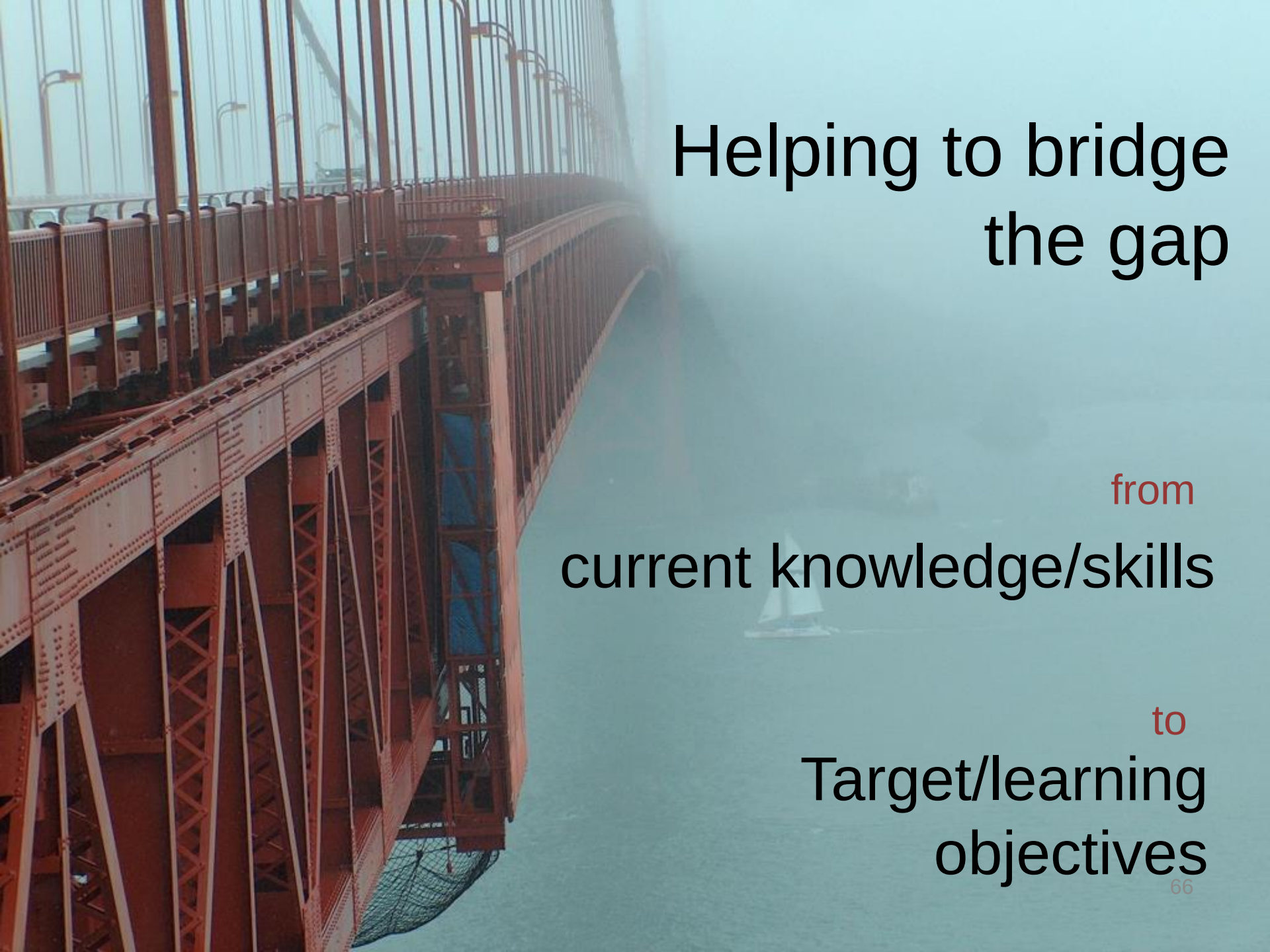
1 of the 7 domains of supervision (MCTQ 2008)

Adjusted his/her teaching activities to my level of experience and competence

Allowed me to perform tasks that fit my level of experience and competence

Was supportive when I experienced difficulty with a task

Gradually decreased the amount of guidance in order to bolster my independence



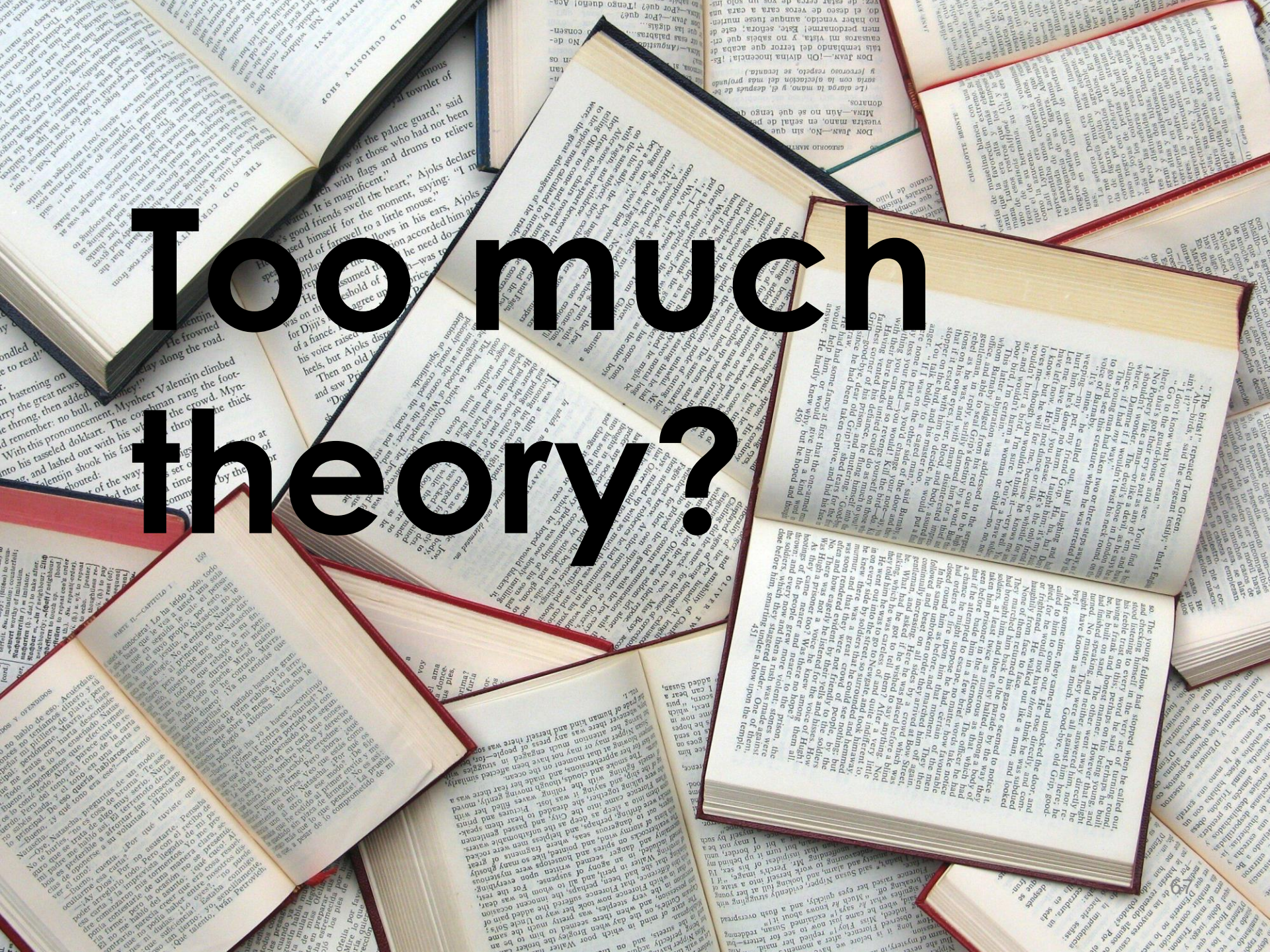
Helping to bridge the gap

from

current knowledge/skills

to

Target/learning objectives


Too much
theory?

Activity 4: Lets do some practice

- Articulate or describe task target (begin with the end in mind)
- Progressive checking of progress and understanding (feedback)
- Develop shared language
- Chunking versus strings of instructions
- Putting yourself in the learner's shoes

Feedback

What are your experiences with feedback?

Feedback

Information on actual performance in relation to the intended goal of performance

(Titchen 1995)

Effective Feedback answers 3 questions

Where am I going? (the goals) **FEED UP ↑**

How am I going? **FEED BACK ←**

Where to next? **FEED FORWARD →**

Feedback Literature

Message 1	Key to Learning
Message 2	Hard to Give
Message 3	Hard to Take

Davids

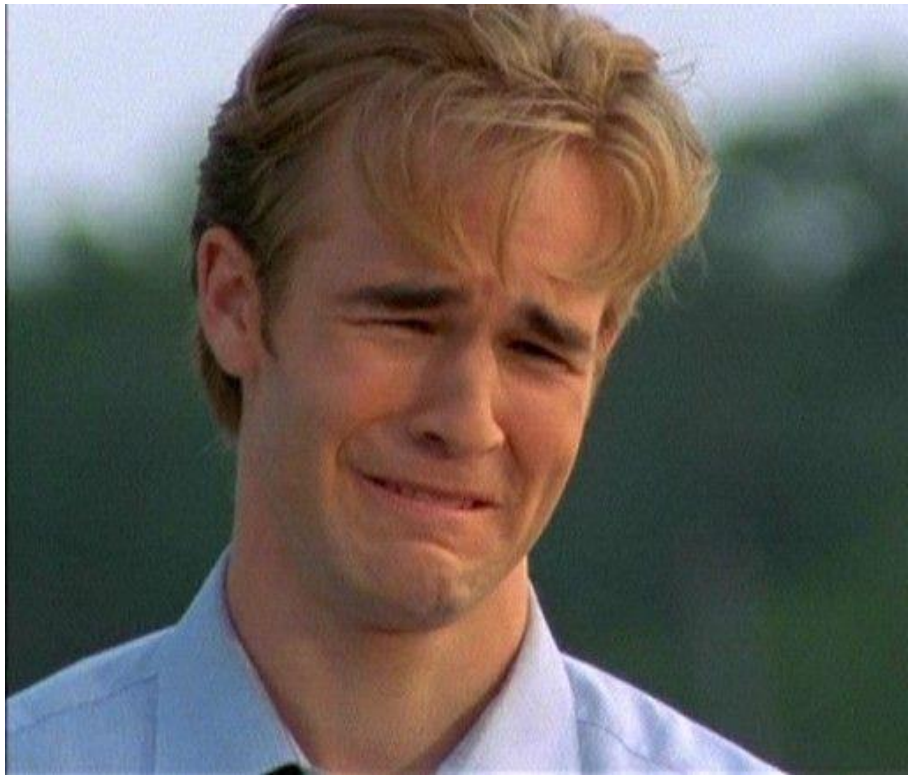
Feedback is *more* than telling

Feedback *does not end* in telling

The two extremes

Damaging Feedback

- ↓ Learner confidence
- ↓ Personal and professional identity
- ✖ Emotive response hinders learning opportunities



The two extremes

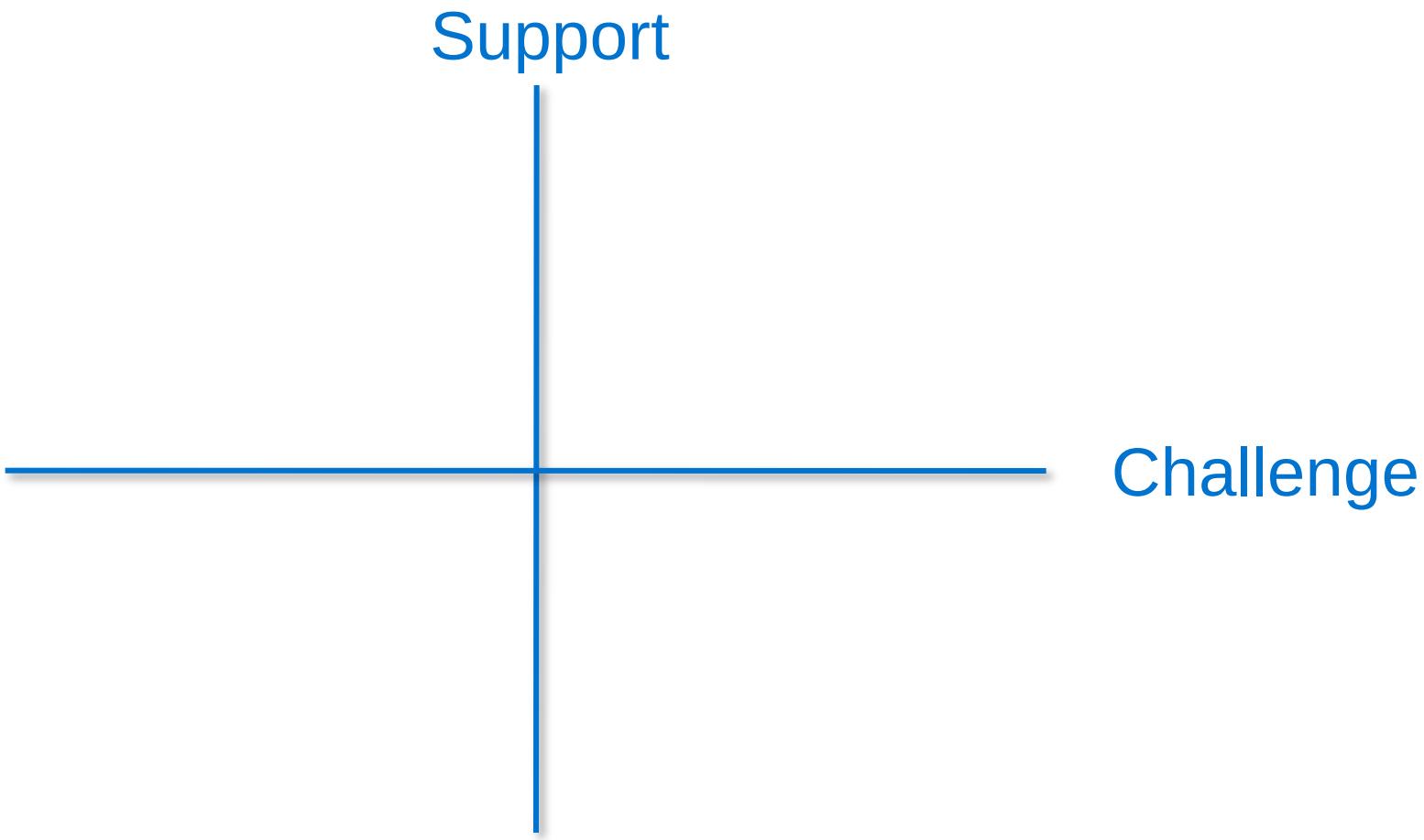
Vanishing Feedback

Tiptoeing around the content to avoid conflict

The message is lost

Ende (1983), Molloy (2006)

The two dimensions



Feedback should be:

Based on observed behavour

Based on behaviour not qualities/personality

Specific

Compared to an explicit standard/target

Based on explicit aim of performance improvement

Followed up with a plan to re-observe task

Ende 1983, van de Ridder et. al. 2008

Higher education literature

Learner surveys have indicated that feedback is one of the most problematic aspects of the student experience

(Carless et al 2010)

Ironically, but not surprisingly, educators typically believe that their feedback is more useful than their students do

(Shute 2008)

Feedback in the HPE literature

Joanna Tai (2009) Systematic Literature Review

Educators and learners at all levels believe feedback is valuable for learning

BUT

There is a disparity in educators' and trainees' perception of feedback in the clinical environment

(Gil 1984, Irby 1981, Irby 1994, Sender Liberman 2005, Hutul 2006)

What ‘sort’ of feedback is provided in clinical education?

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Almost 50% of feedback did not include a specific action plan

Fernando (2008) Medical Education

Models of Feedback

- Pendleton
- Calgary-Cambridge (Silverman)
- SET GO
- Keep Stop Start
- Sandwich

Please, please don't use the sandwich

Pendleton's Model

	Learner	Observer
Positive aspects	1	2
Areas for improvement	3	4

Pendleton's model

1. Ask learner how they felt
2. Ask learner what went well and why
3. Teacher says what went well and why
4. Ask learner what could be done better & how
5. Teacher says what could be done better & how
6. Summarise strengths and up to 3 things to concentrate on

Activity 5:
Practising the Pendleton Model

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In the same triad from the dominoes activity:

The ‘observer’ provides feedback to the ‘educator’ on their teaching skills in the dominoes activity

The third party will provide feedback to the feedback provider (on their feedback skills)

What are the pros and cons of models?

What are the benefits of using a template/model for feedback

Disadvantages?

When might it be inappropriate to use a two way model of effective feedback?

Feedback Research (Molloy 2006)

‘One way’ feedback culture

Tokenism

Feedback: A monologue-ic culture

Average time for FB sessions = 20 minutes
Average time for learner input = 1 minute
Learner contribution = approx 5%

1. One-way feedback culture

Minimal learner self-evaluation

Minimal learner preparation for the sessions

Almost no collaborative development of strategies for improvement

2. Tokenism

“ We’ve all got time restraints so you know, saying ‘what did you do well?’ and then giving feedback, it all takes extra time and that’s an issue as well. And you know, I find myself saying to the learner ‘OK, what did you think?’ and then hoping inside me that they’ll be really quick about what they want to tell me.”

Clinical Educator

Tokenism

In 16/18 videotaped sessions, educators opened the with an invitation for learner self-analysis

Educator: *"So I just want to find out a little bit about how you think you are going with the placement?"*

Learner: *"I've enjoyed it so far. I've enjoyed the supervisors. They are always challenging us and make us justify what we're doing and why"*

Educator: *"OK, so that's where we think you're at, at this stage"* (shows assessment sheet)

What are the constraints to enacting a 2 way model of feedback?

What are the constraints to enacting a 2 way model of feedback?

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Supervisors

Supervisors may be limited in time (balancing patient load and learner load)

Supervisors may not be skilled in facilitating trainees' self-evaluation

Supervisors' tendency to 'diagnose' and 'fix' rather than collaborative decision making

Supervisors adhering to established feedback culture using 'script'

Constraints…

Learners

Learner reticence to evaluate their own performance through fear of being wrong

Learner ‘positioning’ of the educator as content/practice expert

Learner concern in challenging supervisor’s view due to reasons of power/hierarchy

Learner perfectionism and concern for assessment rather than learning

Without this framing…

Information on the goal of performance

Information about how performance meets the goal, commonly referred to as the ‘gap’

Strategies to address the gap

(Sadler 1989)

Feedback is simply

"Dangling data"

Sadler 1989 p. 121

Clinical Assessment

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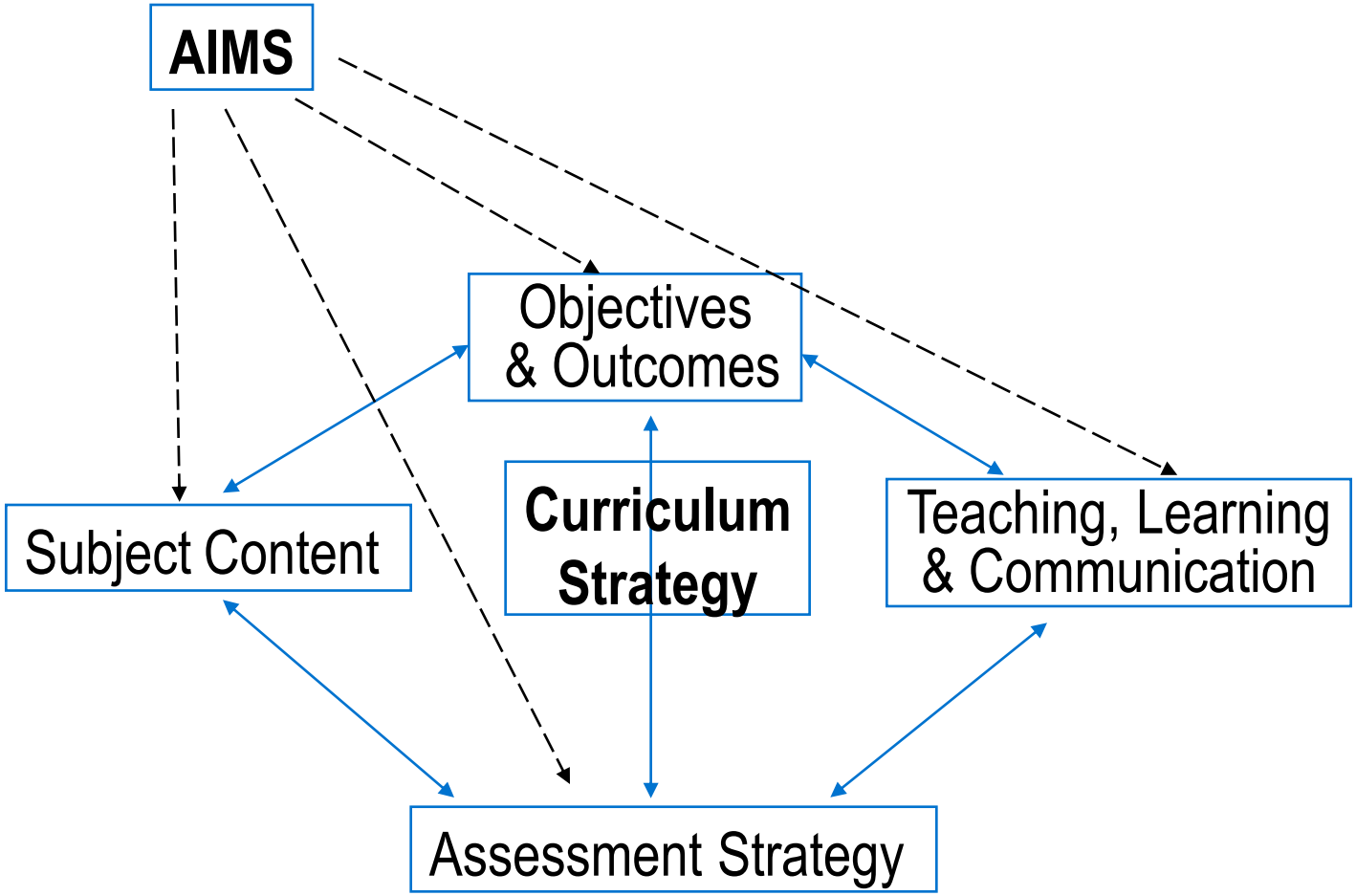
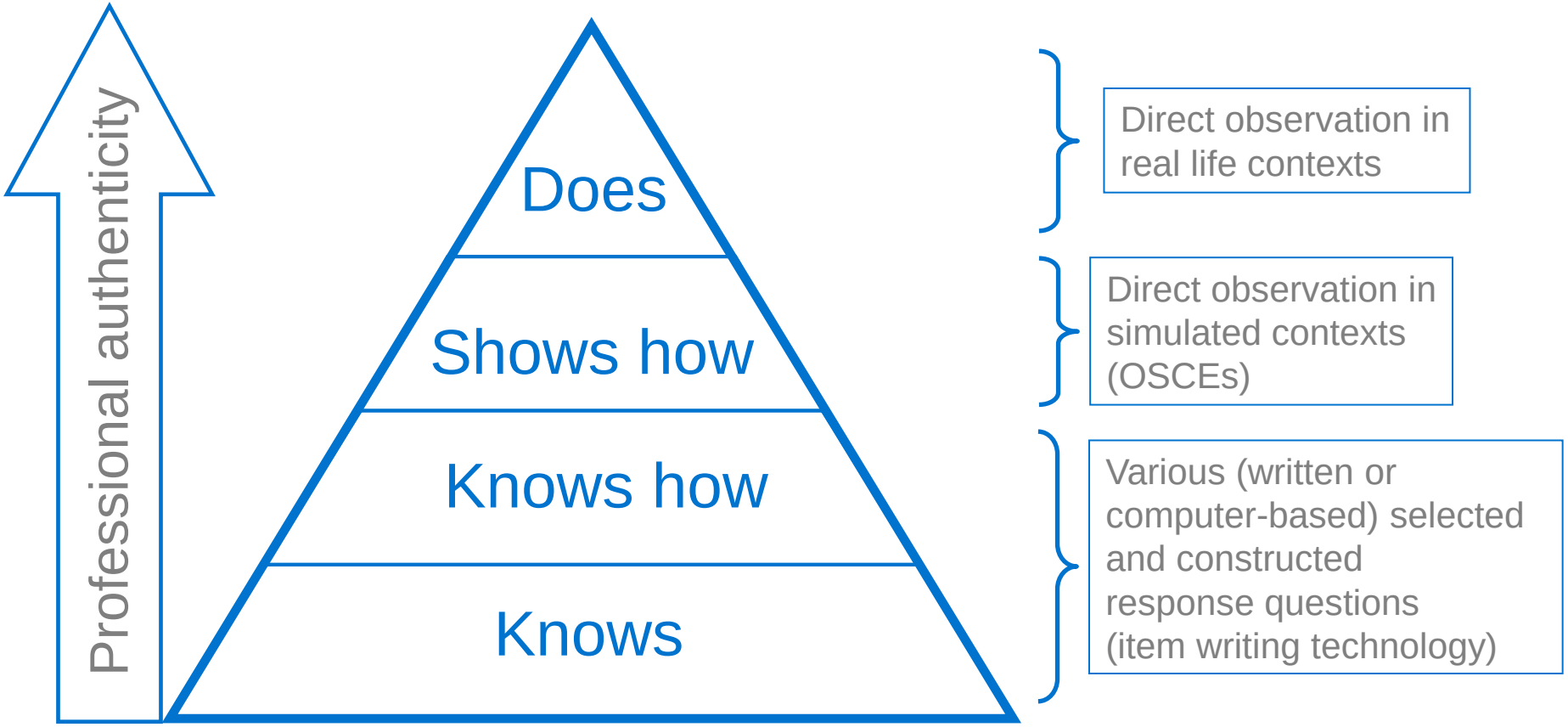
Assessment drives learning

Assessment can drive out learning

Eraut's Model of Curriculum



Miller's Clinical Competence Model



Miller GE. (1990) The assessment of clinical skills/competence/performance. Academic Medicine (Supplement) 65: S63-S67.

Assessment

Role of summative assessment

Gatekeeping and decision making

Recognition of superior performance

Record keeping and communication to others

Accountability on the part of the educators and the program

ASSESSMENT – Instrument

Reference tool for the student

Guide reflection and strategy development

Assist evaluation of self assessment capacity

ASSESSMENT – Process

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Gather information:

Observe

Question

Test - formalised, case presentation, written assessments

Listen – to questions, hand-overs, reports

Review paperwork – planning sheets

Use peer commentary

Use patient commentary

ASSESSMENT – Process

Make decisions

Relate information to specific criteria

Refer to performance indicators for clarification

Facilitate learning through the assessment process

CanMEDS

The Royal College of Physicians and Surgeons of Canada

5 point scale to measure clinical competency

Frank, JR., Jabbour, M., et al. Eds. Report of the CanMEDS Phase IV Working Groups. Ottawa: The Royal College of Physicians and Surgeons of Canada. March, 2005.

CanMEDS Framework

Seven domains:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar
- Professional

When to assess?

Need formal staging posts for assessment

Ensure these are understood and agreed to by the student

Initial interview (formative, directional)

Mid-placement (formative, diagnostic)

End of placement (summative, gate keeping)

Other points in clinical assessment

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If you don’t see it, don’t mark it

Ensure you schedule to see what you need to fully assess the student

Do not negotiate the outcomes

Be mindful of own bias

Best Practice for Assessment in the Clinical Setting

Dalton 2009

Cognitive Bias

When an overall impression or specific characteristic of the student influences ratings.

Integral Assessment Program

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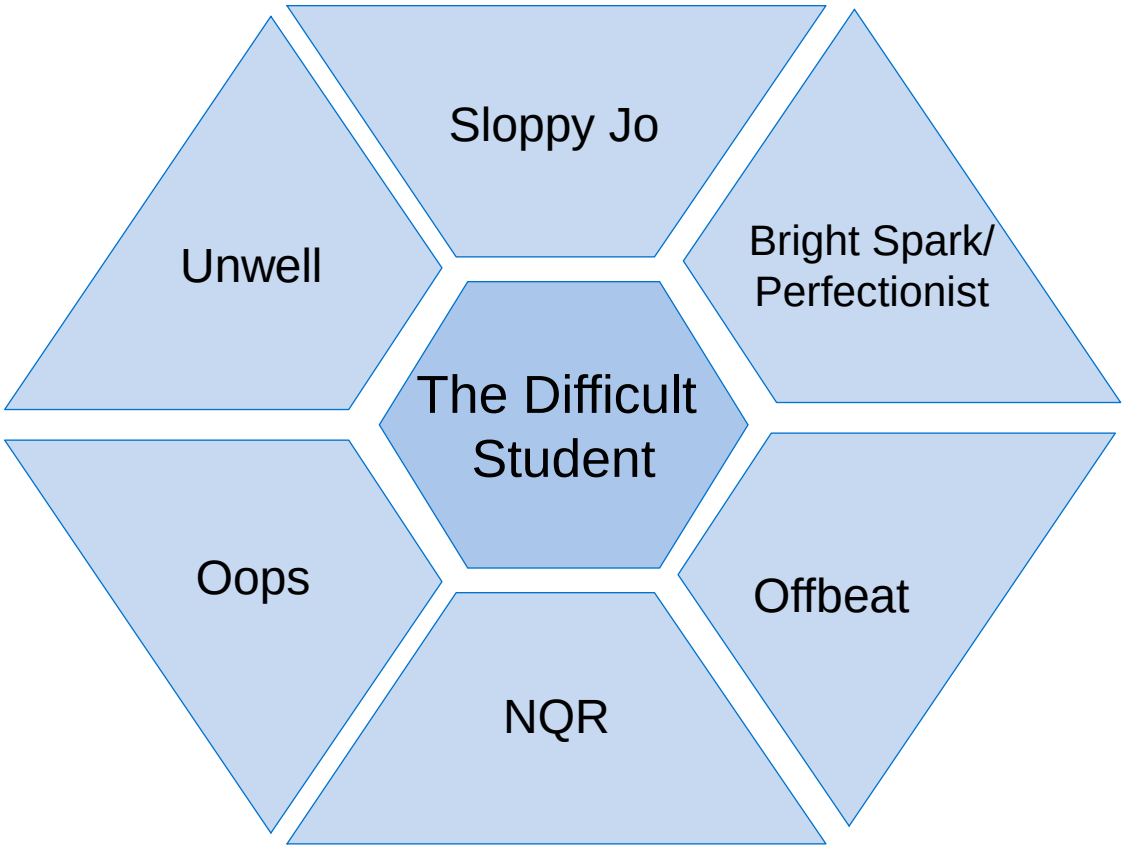
Assessment is intertwined with the overall education program - “systems approach”

Schuwirth, L.W.T., & van der Vleuten, C.P.M. (2006)
van der Vlueten, C.P.M., & Schuwirth, L.W.T (2005)

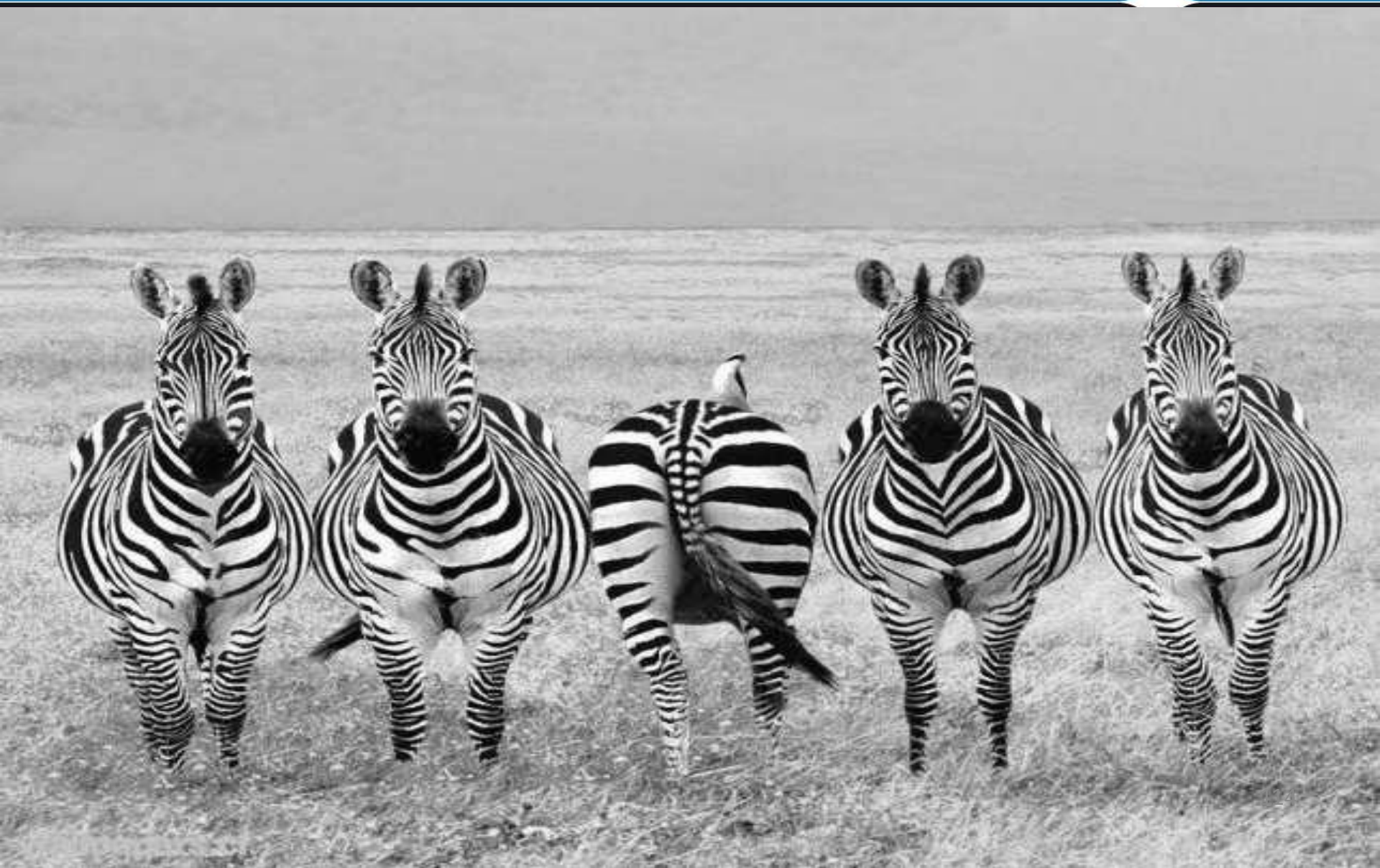
Working with the Poorly Performing Learner

Categories of the poorly performing student



Richard Hayes &
Mary Lawson
Ottawa 2008

The unmotivated / disengaged learner



Research on the poorly performing learner

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How do clinical educators typically respond to encounters with PP learners?

Bearman, Molloy, Ajjawi and Keating (2011)

MORE…

MORE…

MORE…

What strategies do clinical educators use to manage this situation?

More energy

More empathy

More direct supervision

More verbal feedback

More more more

"I've put an expectation on myself that I'd like to be there as much as I can possibly can be for the student" FG3

"When you're with a needy student, they just tend to suck you into a vortex so that you spend your entire time with them, helping them" FG1

More more more

- “On a personal level it’s exhausting because I want the student to get over the line” FG3
- “Part of you feels as though you’ve failed if you can’t get the student through” FG1
- “The worst thing that we can do [as educators], I think, is borrow their anxiety as our own” FG1

More vigilance in surveillance

"You're juggling between giving the student the autonomy and the independence, versus your patient's safety..."

FG3

Over vigilance vs student autonomy

"At the start of the placement, when you are finding out where students are at, it's hands on…and then as they show you that they are capable in various areas then you do take your hands off…and move gradually into them managing things themselves" FG3/22

"But you gotta let go though, especially towards the end, you've really just gotta let go" FG1/11

"Your learning sky-rockets once you are given autonomy" FG2/5

"You can step back and they can actually help you with your workload" FG3/20

Solution focused model

‘Glass half full’ philosophy!

Generate solutions rather than focus on problems

(Devlin, 2003)

Tenets of SFM

1. The goal of the intervention is determined by the learner based on learner's context, resources and strengths…

Learner insight into workable solutions…

Educator helps devise solutions…

Tenets of SFM

health

2. Change is viewed as inevitable and positive change is likely

"When" not "If"…

Focus on the future not the past!

Tenets of SFM

health

3. Look for exceptions to problems…

Find examples of clinical practice when the problem does not occur

These ‘exceptions’ are where the solutions can be found

Tenets of SFM

4. Interventions should be strategically chosen, employed and re-assessed…

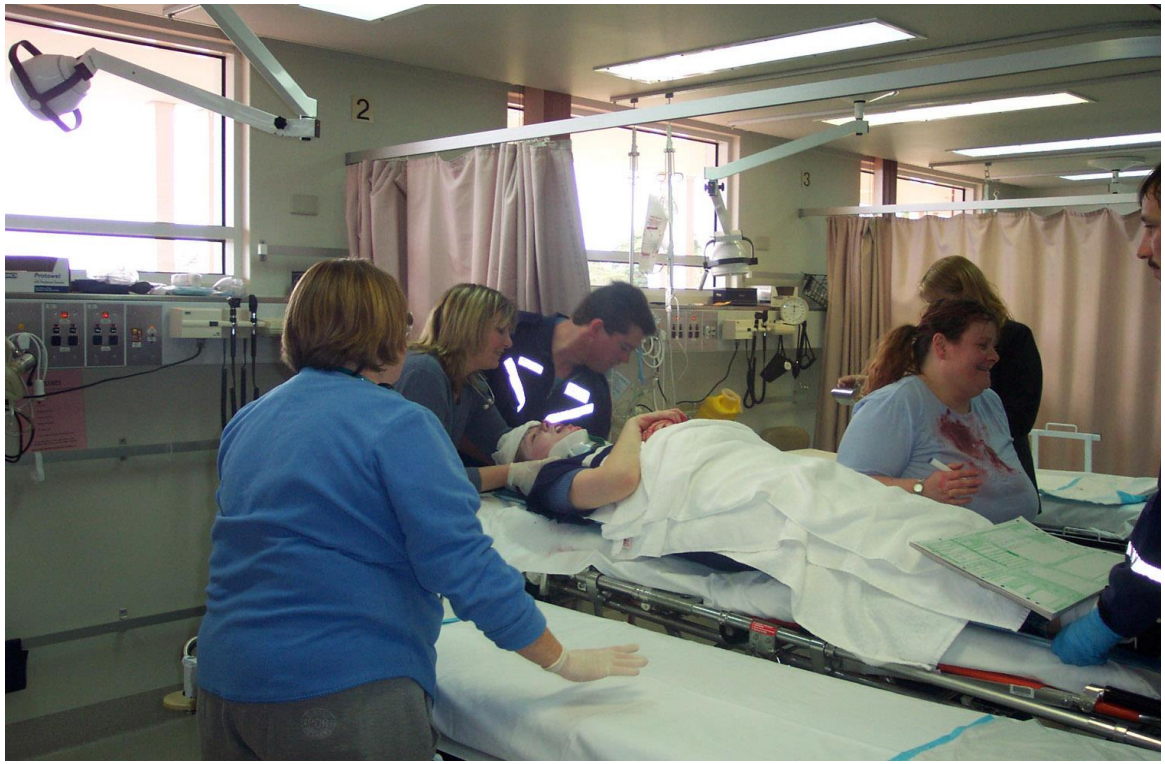
If it works continue..

If it doesn't then try a different approach…

For a person to change, they need to:

- Recognise the current behaviour is a concern or problem
- Believe they will be better off if they change
- Believe they are able to change

Remediation activities



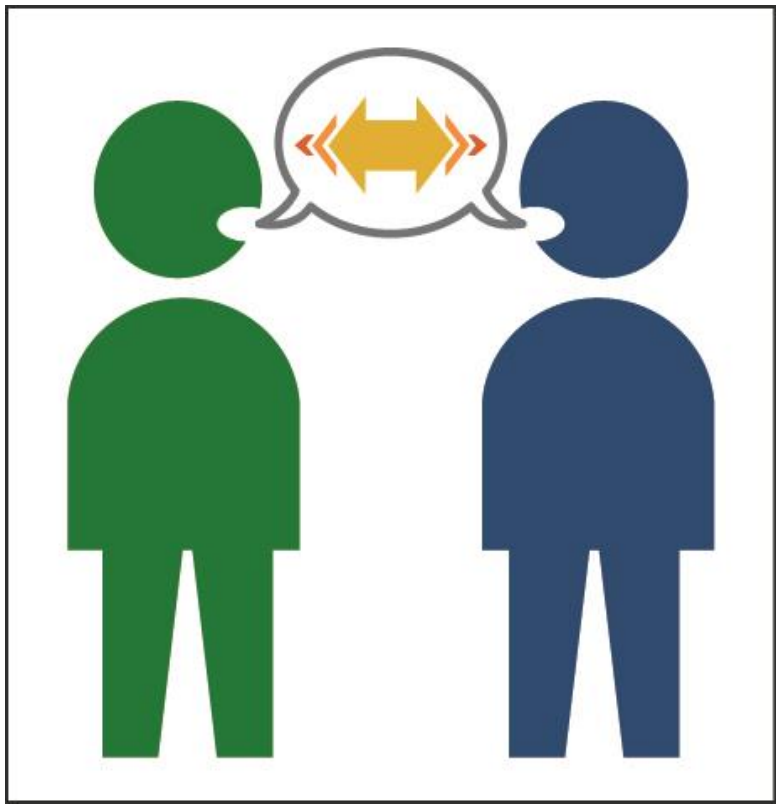
Clinical observation

Video analysis of student performance

Remediation activities

Practice with simulated patients

Remediation activities



Intensive feedback and individual performance review

Remediation activities

Individual tutoring/instruction

Activity 6

In groups of 3, think about a scenario where the learner has under-performed

Using the theory discussed, identify:

1. What are the presenting problems?
2. How will you approach the learning/performance deficit? (strategies)
3. How will you know if you have been successful?

Strategies

- Identify issues early – provide clear communication re. learning needs & expectations
- Observe and collect data
- Diagnose strengths and deficits (collaboratively)
- Provide regular feedback
- Have a clear plan – SFM
- Utilise resources and make your intervention clear
- Document the process
- Be prepared to act on outcomes of assessment

Workshop summary

Participants to provide

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