Remote Supervision

Guidelines for safe and effective general practice training utilising remote supervision

RACGP

Remote Supervision: Guidelines for safe and effective general practice training utilising remote supervision

Recommended citation

The Royal Australian College of General Practitioners. xxxxx cover title xxxxx. East Melbourne, Vic: RACGP, 2022.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002
Wurundjeri Country

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN: 34 000 223 807
ISBN: XXXXX

Published 2022

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-4851

Contents

Acknowledgements

Remote supervision team

Associate Professor Jill Benson AM, National Lead Medical Educator Remote Supervision, RACGP
Dr Tim Linton, National Lead Medical Educator Remote Supervision, RACGP
Ms Stacey Cotter, Project Manager, RACGP

The publication of this guide was made possible through support and funding from the Australian Government Department of Health.

The Royal Australian College of General Practitioners (RACGP) and the remote supervision team gratefully acknowledge the generous efforts of the following contributors to the development of the remote supervision guidelines.

Associate Professor James Brown, National Director of Training, RACGP
Dr Karin Jodlowski-Tan, National Deputy Director of Training Rural Pathways, RACGP
Ms Josephine Borthwick, Evaluation Lead, RACGP

Please note that the following committees were active during 2021, and the role titles mentioned reflect that time period. Committee members' titles and organisations may have since changed.

Remote supervision project steering committee (2021)

Mr Russell Baker, Transition Program Manager, RACGP
Associate Professor Jill Benson AM, GP Senior Medical Advisor, Remote Supervision, RACGP
Associate Professor James Brown OAM, Principle Medical Education Advisor, RACGP
Ms Angela Burden, Operations Manager, RACGP
Dr Judith Culliver, National Clinical Lead Education Strategy, RACGP
Dr Gerard Ingham, GP Senior Medical Advisor, Supervisor Professional Development Program, RACGP
Dr Tim Linton, GP Senior Medical Advisor, Remote Supervision, RACGP
Dr Karen Nicholls, RACGP Aboriginal and Torres Strait Islander Health
Dr Tony Saltis, GP Senior Medical Advisor, Supervisor Professional Development Program, RACGP
Dr Ken Wanguhu, Censor, RACGP Rural

Remote supervision expert advisory group (2021)

Professor Marlene Drysdale, Senior Aboriginal Health Educator and Advisor, EV GP Training
Professor Richard Hays, Remote Health and Medicine, James Cook University
Dr Gerard Ingham, GP Senior Medical Advisor, Supervisor Professional Development Program, RACGP
Dr Karin Jodlowski-Tan, National Clinical Lead, RACGP Rural
Dr John Kelly, Remote Supervisor, Northern Territory General Practice Education
Dr Prashanti Manchikanti, Remote area GP, Northern Territory
Associate Professor Lawrie McArthur, Director, General Practice Training, James Cook University
Dr Rodney Omond, Deputy Chair and Northern Territory Representative, RACGP Rural
Mr Glen Wallace, CEO, GP Supervisors Australia
Clinical Associate Professor Susan Wearne, Australian National University; Senior Medical Adviser, Health Workforce Division of the Department of Health

Background

Overview

Remote supervision of general practitioner (GP) registrars aims to provide them with options to work in locations where there is limited or no regular onsite GP supervisor.

The quality of supervision is a key determinant both for patient safety and for attracting GP registrars who are willing to work in isolated environments. Rather than viewing remote supervision as 'second-best training', these guidelines have been developed to facilitate supervision and learning that is comparable to, if not better than, the traditional supervision where the registrar and supervisor are working in the same building or for the same medical service.

The remote supervision guidelines are designed to be flexible and need to be contextualised to each registrar and placement. These guidelines are only formally applicable to training sites and supervisors that are accredited by The Royal Australian College of General Practitioners (RACGP), although they may be used to inform other remotely supervised training.

Why we need remote supervision of GP registrars

There is an urgent and increasing need throughout Australia to build and sustain the rural and remote GP workforce. Approximately 29% of the Australian population lives in rural and remote areas, where the ageing population has a higher mortality and morbidity rate due to chronic disease, multimorbidity and injury.

In 2013, Australians had access to 274 doctors per 100,000 in remote/very remote areas, compared with 433 doctors per 100,000 in major cities.[1]

It has been well established that the total disease burden in rural and remote areas is higher, with poorer health outcomes, more barriers to accessing healthcare and a greater reliance on GPs to provide a wider scope of services.[2] There are fewer GPs in outer-regional, remote and very remote locations, with the percentage of GPs choosing to work in rural and remote Australia declining.[3] This is even more pronounced in remote Aboriginal and Torres Strait Islander communities, where the increased burden of disease means there should be more doctors per head of population, as well as an increased availability of longer consultations.[4]

The patients in these areas often have limited access to safe and timely local medical services. Even when there is a doctor present, many new doctors who are working in rural and remote areas have little previous experience, current oversight, appropriate qualifications or support for the work they are doing.[5] Local GPs may be overloaded with their own clinical practice and not have the time or enthusiasm to supervise a GP registrar, with many close to burnout. Access to primary healthcare services ensures that prevention, early intervention, continuity of care and managing chronic health needs are addressed.

Providing training in these settings is essential to develop GPs with relevant skills for the scope of practice required by regional, rural and remote communities.[1] Those who are trained in such areas of need are more able and willing to continue to work there after qualification and will fill a need in many areas during their training.

In the Northern Territory, registrars play a particularly vital role in the provision of primary healthcare in remote areas. In addition, the future success in closing the gap in Aboriginal and Torres Strait Islander health outcomes is heavily reliant on a well-coordinated and well-supported general practice workforce and training system.

Remote supervision of GP registrars has been occurring in pockets of Australia for many years using diverse models. Although educators may be anxious that remote supervision is not as safe, there is no evidence of harm with remote compared with onsite supervision.[6] Good remote supervision may be better than poor onsite supervision, and is definitely better than no supervision.[5]

There is evidence that a well-supported model designed specifically for remote supervision 'facilitates the creation and maintenance of professional connections and support'.[7] The use of telehealth, such as videoconferencing, email, telephone and remote access to patient information, and even patients themselves, can also alleviate the time, cost and resources required to supervise a registrar remotely in a remote situation compared with face-to-face supervision.

Supervision involves providing monitoring, guidance and feedback on matters of personal, professional and educational development in the context of the registrar's care of patients.[5] This would include the ability to anticipate a registrar's strengths and weaknesses in particular clinical situations in order to maximise patient safety.[5]

Good supervision is based on a strong educational alliance that is much more than just clinical advice. The presence of a supervisor does not necessarily lead to good supervision; this requires a 'sound professional relationship, self and mutual awareness of strengths and weakness, confidence to seek and provide help at any time, and the ability to provide and receive appropriate feedback'.[8]

In an effective remote supervision model, the registrar is supervised not only by their designated supervisor, as would mostly occur in a mainstream urban practice, but also by a team, which may include the Aboriginal health worker/practitioner, practice manager, nurse, local tertiary services and other multidisciplinary community-based health services. This not only expands clinical knowledge, but also builds up an 'amalgam of role models and richer learning than interaction with a single supervisor'.[6]

In Australia, 'rural generalism' is a broad term encompassing practice in rural and remote areas. Ensuring that GP registrars are effectively supervised in order to develop rural generalism skills has proven difficult in many areas, and remote supervision may be an essential strategy to ensure the future rural generalism workforce is maintained.

> *Generalism is a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger healthcare team, in order to respond to patient and community needs … Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients.*[9]

Rural generalist training involves not just knowledge and skill development, but also the development of wisdom, and is best done in collaboration with the local community.[10]

Flexibility is needed to contextualise the specific requirements of the practice and community with the skills of the registrar and supervisor. A process for tailoring and evaluating the needs and outcomes for the registrar, supervisor, practice and patients will ensure that the diversity of people and environments are well matched, and outcomes are safe.

Patient needs

The more nuanced aspects of training in isolated remote Aboriginal and Torres Strait Islander communities and other disadvantaged groups can only be learnt 'on the ground'. This will include the interdependent relationship between a patient's illness and their psychological, biological, social, economic and cultural circumstances. These factors can influence the presentation of an illness, the doctor–patient relationship, engagement with investigations, expectations, management and recovery.[11]

Registrars who are remotely supervised are responsible for promptly finding evidence-based and contextually appropriate answers to problems, which may mean contacting the remote supervisor, other

members of the supervision team or seeking help on the internet or in textbooks. Research has shown that patients often prefer this approach to a long wait for a visiting specialist or travelling away from their homes to a distant hospital.[6]

There is concern that patients may not be comfortable consulting a remotely supervised registrar rather than a more experienced GP. However, research has shown that, from the patients' perspective, receiving care from a junior doctor who respects their autonomy, uses an interpreter, is explicit about their level of experience and is remotely supervised via videoconference may be more 'safe than transfer to an expert who works in the alien environment of a large teaching hospital'.[5]

> *There is a perceived increase in the quality and continuity of healthcare resulting from more trainees working in the community, rather than an ever-changing supply of locums … Therefore, there is improvement, not only in overall health status and outcomes, but also specifically to accessibility, continuity and quality of healthcare, including preventive healthcare services, and the availability and sustainability of the rural GP workforce.*[12]

Supervisor needs

There is a balance that needs to be reached for effective supervision between the level of support for the registrar and the challenges they confront. Giving appropriate feedback and promoting reflection on a background of a strong educational alliance will ensure that it is safe for the registrar to 'reveal and address weaknesses in his or her knowledge, skills and emotional responses to practice'.[5] Attending to the registrar's wellbeing, supporting them through challenging situations and brokering their relationship with the practice and the community are also essential elements of the supervisor's position.

GPs choose to take on a role as a supervisor for various reasons, such as altruism, an interest in improving general practice quality, increasing the general practice workforce, sharing values and knowledge and believing teaching to be part of a GP's role.[13] Teaching also improves morale and increases professional support and the sense of collegiality.[13]

Whatever form remote supervision takes, it should facilitate learning, ensure patient safety and help the registrar in their development of professional identity. Continuity of the supervisor allows for the development of a relationship of mutual respect and trust, which will facilitate discussions about any personal issues, vulnerabilities and dilemmas that 'go to the heart of being a health professional'.[5]

As the GP population ages over the next 10 years, many GPs may be looking for flexibility, such as part-time teaching along with their clinical work, particularly in order to reduce their risk of burnout. Such a move may prevent their early retirement and 'loss of their wisdom' from general practice'.[14] Others may be interested in providing locums in rural areas or doing telehealth along with fly-in, fly-out (FIFO) work.

Accessing GPs who are willing and able to take on a role as a remote supervisor may mean targeting those senior clinicians with rural, remote and contextualised experience and interest who may otherwise be retiring and completely lost to general practice. There is already some literature outlining how 'gaps in the ability of local staff to provide clinical supervision would be supplemented … to create a supervision team with local contextual and subspecialty expertise'.[15]

GP registrar needs

It has been found that registrars who are remotely supervised are more resourceful in seeking answers to their clinical questions,[16] receive feedback on clinical decisions they have made autonomously,[5,17] learn how to cope when immediate advice is not available and develop skills that will assist them with practising independently as a Fellowed GP.[18] A period of remote supervision is expected to help bridge gaps in preparedness by demonstrating to registrars what else they need to learn for competent, independent practice at a stage when they still have access to supervision and support.[5]

Providing remotely supervised registrars are not overwhelmed by the responsibility, there is an argument supported by the literature that learning occurs best with remote supervision, because remotely supervised registrars are likely to be working at the limits of their confidence and ability. For instance, those who have supervisors nearby may ask for assistance without going through the full process of problem solving and clinical reasoning.[5–7]

In addition, remote supervision will increase opportunities in rural and remote communities, where the scope of practice will be increased, not only adding to a registrar's clinical learning, but also contributing to their professional and personal resilience and increasing their professional confidence.[1]

Finally, a quality orientation program, the support and advice of the local team, being embedded in the organisation and their integration into the community widens a registrar's professional and social learning even more in other domains outside clinical medicine. Although the learning opportunities in remote supervision are enhanced in comparison to onsite supervision, the experience must be underpinned by a clear registrar support program. Without ample opportunity for reflection, networking and/or peer support, there is a risk of isolation that will jeopardise both the registrar's learning and the likelihood of them being retained in remote locations.[19] Indeed, compulsory rural placements have been shown to be a negative experience for many registrars and to be unlikely to increase the future rural workforce.[20]

Evaluation of the success of remote supervision will include assessments of processes, the training and the safety. However, the real success will be seen when registrars stay in the community after completion of training, or recommend that their colleagues train with remote supervision.

Guidelines for remote supervision

Introduction

Remote supervision should be comparable to, if not better than, traditional face-to-face supervision. To achieve this, certain minimum standards must be met.

These evidence-informed guidelines have been developed with the objective of ensuring the safety of the registrar's patients, the registrar themselves, the supervisor and the training site while providing a foundation for a high-quality learning experience. We encourage readers to consider other issues and processes that extend beyond these guidelines and determine what is contextually relevant for their local environment.

Fundamental to remote supervision is the identification and selection of the right location, suitable registrar, onsite supervisory team and an appropriate and effective supervisor. It is hoped that registrars who are remotely supervised will develop strong skills in assessment, differential diagnosis and management and, with supervisor support, be able to implement safe and appropriate medical care.

What is remote supervision?

Remote supervision is when supervision and teaching are provided by a supervisor who is primarily offsite, using a model of supervision that provides comprehensive and robust support and training. The supervisor is 'remote' from the registrar.

How to use the guidelines

It is expected that most remote supervision training sites will be in rural and remote areas, although the guidelines could be applicable in any location that does not have access to an accredited onsite supervisor. Remote supervision should be considered when onsite supervision cannot be provided by an accredited supervisor.

The guidelines provide for several key differences between face-to-face supervision and remote supervision. Each of these components needs to be contextualised to the training site, supervisor and registrar. Each location, situation and placement is different, and needs to be treated as such.

Key differences between remote supervision and traditional on-site supervision:

- Selection of supervisor and registrar using a contextualised remote supervision placement process (CRSPP)
- Risk management planning to assess and manage current and potential risks in the placement
- A face-to-face-orientation period when the supervisor and registrar work together
- Development of an onsite supervision team
- Communication strategies for clinical, professional and personal support and assessment using IT
- Acknowledgement of the increased time required for remote supervision with additional payment for offsite and onsite teaching, support and assessments.

Application of the guidelines will vary and depends on the training program (ie Australian General Practice Training [AGPT] program, Fellowship Support Program [FSP], Remote Vocational Training Scheme [RVTS]) and the registrar context (eg Australian Defense Force [ADF] registrars). Relevant components of the guidelines must be applied to ensure high-quality training is delivered and training outcomes are achieved.

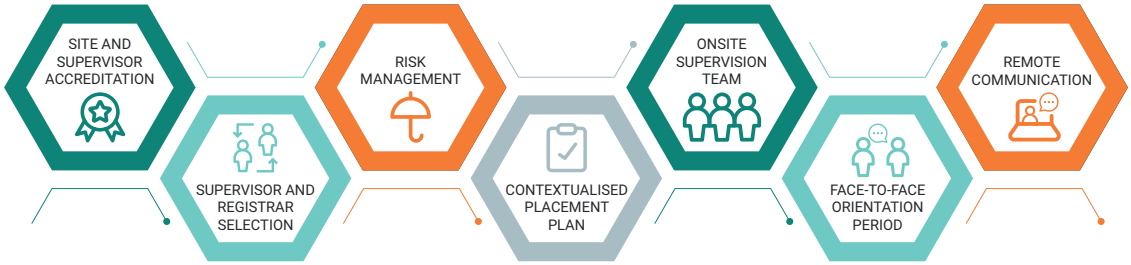

Figure. Overview of remote supervision processes.

Models of remote supervision

There are a number of models of remote supervision that can be applied, depending on the context of the training site and the availability of the remote supervisor.

Model	Description	Examples of how the model might work in practice
Remote supervision	Registrar is supervised by a remote supervisor who lives anywhere in Australia	• There may or may not be a non-supervising GP or locum at the training site • If there is another onsite GP, it may be arranged that they provide support during emergencies
Blended supervision	Registrar and remote supervisor work in the same location for a period of time throughout the placement, with periods of remote supervision	• Registrar may work in a location where the remote supervisor may be a regular FIFO locum • Both registrar and remote supervisor may be FIFO in a 'roving registrar' model and visit multiple locations (up to six) regularly together or separately
Satellite supervision	Registrar is supervised by a remote supervisor in a neighbouring or nearby town who is available for some face-to-face meetings and supervision	• Registrar may work exclusively in a satellite clinic of the main clinic where the supervisor works • Registrar may work in both the main practice and the satellite clinic, with the remote supervisor only working in the main practice • Registrar may work in both the main practice and the satellite clinic, with the remote supervisor also working in both practices, but not simultaneously with the registrar • The main clinic and satellite clinic do not necessarily have to be connected • Two weeks orientation could be either in town clinic, satellite clinic or a blend
Group supervision	Multiple remote supervisors support multiple registrars remotely and rotate their days of support	• Up to five remote supervisors support up to five registrars • Each registrar will have a one-on-one relationship with one of the supervisors, who will be their primary remote supervisor and will usually be the only supervisor doing face-to-face work with them • Each remote supervisor works as the dedicated supervisor one day per week and supports all remotely supervised registrars on that day • Remote supervisors would usually not have their own patient consultations on days they are working in this role and could do administrative tasks (eg results, reports) between training calls and scheduled activities (eg assessment and external clinical teaching visits)

Remote supervision training minimum requirements

Remote supervision is not just traditional supervision occurring remotely. There are challenges that will need to be addressed, as well as extra time, logistics, guidelines, support and payment that will be required to ensure the supervision is serving its purposes. Virtual contact will always take longer than ad hoc face-to-face support and will need to be more organised, and often pre-emptive. Remote supervision needs to encompass the full spectrum of 'supervision' activities, including clinical oversight, teaching, mentoring, role modelling, coaching, career support, advocacy and nurturing.[21]

The table below lists key remote supervision activities and the indicative resourcing required for the registrar, depending on their general practice and remote supervision experience. This table should be used to determine the appropriate plan for the registrar's placement. Considerations include the registrar experience, remote supervisor availability, the onsite team and the context of the training site. Flexibility is also required to respond appropriately to the needs of the registrar.

Note: Registrars undertaking a remote supervised placement will participate in all training and education activities as required by their training program.

Activity	GPT2/second term	GPT3/third term	GPT4/fourth term
Remote supervision orientation (per placement/site) Registrar and remote supervisor spend one to two weeks together to build education alliance and assess appropriateness of the training site This is crucial for a successful remotely supervised placement	Two weeks, mostly supernumerary	Two weeks, mostly supernumerary	One to two weeks, mostly supernumerary, based on registrar's experience
Weekly remote supervision This includes all teaching, registrar support, ad hoc communications, assessment and some regular quarantined time for the remote supervisor and the registrar It also includes in-practice teaching time requirement	Three to four hours per week	Three hours per week	Two to three hours per week
Mid-term site visits A site visit is ideally conducted by the remote supervisor	One to two visits	One to two visits	At least one visit
Onsite team meetings Regular check-ins between the onsite supervision team (or team representative), registrar and remote supervisor	Every one to two months	Every one to two months	Every two months

Establishing a remote supervision placement

Establishing a remote supervision placement involves the assessment and selection of a training site, model of remote supervision and selection of the supervisor and registrar. The identification and selection of the right training location, a suitable registrar and an appropriate and effective supervisor are fundamental for a safe and successful remote supervision placement.

The selection of the training site, supervisor and registrar will be an iterative process and require communication between multiple stakeholders. Initial requests for selection could follow a registrar initiative regarding working in an area without current onsite supervision, a response to a need from a community, the identification of a site by the workforce planning team or from observations by the local RACGP team. Workforce planning and prioritisation and organisations' workforce needs and training capacity reports are further sources of clarity on potential sites for remote supervision through the confirmation and prioritisation of areas of workforce need. As this information is overlaid with RACGP data on training sites and supervision, it may become apparent where remote supervision can/should be considered.

The RACGP's remote supervision snapshot provides an overview of the process of establishing and managing an AGPT remote supervision placement. The process is not necessarily sequential, and some steps may occur in parallel.

The training site

Remote supervision training site eligibility and selection

To be eligible for remote supervision, the practice needs to have a workforce and community need; that is, these locations have a need for a GP and a clear desire from the community for someone to fill this role. It is expected that most remote supervision training sites will be in rural and remote locations, although the guidelines could be applicable in any location that does not have an accredited onsite supervisor.

Eligibility requirements include:

- No (or very limited access to) onsite accredited supervisor
- Willingness to engage a GP registrar and to provide cultural support
- Adequate consulting space and equipment appropriate for a remotely supervised registrar
- Suitable, stable and safe housing
- Good reliable IT connectivity
- A willingness to establish an onsite supervision team.

Identification and ratification of a new remote supervision training site will be a collaborative effort by the RACGP regional and relevant local team, the accreditation team, the remote supervision team and the state censor. This will involve a detailed discussion between the training site, the RACGP and, potentially, the community about factors that may impact the implementation of a remotely supervised placement.

Determination of the model of remote supervision suitable for a training site should follow from a discussion with the training site and other key stakeholders. It will be influenced by a number of factors, including the availability of supervisors, nearby practices, the clinical needs of the training site, the scope of practice for the registrar and local retiring GPs.

Remote supervision training site accreditation

Accreditation of remote supervision training sites will follow usual RACGP processes as per the National Accreditation Framework, with additional criteria and activities specific to remote supervision. To achieve accreditation as a remote supervision training site, the training site must meet the RACGP Accreditation standards for training sites and supervisors and the additional remote supervision requirements as per the Remote supervision training site accreditation requirements. These include:

- review of the RACGP remote supervision guidelines
- completion of the remote supervision training site requirements table
- provision of a draft outline of the onsite supervision team that will support the registrar during the remote supervision placements (the team can be further developed closer to the placement and during the orientation period)
- review of the Remote supervision risk management template and starting to think about potential risks and mitigation strategies relevant to the site (this will be completed during the orientation period with the remote supervisor and the registrar).

The RACGP should be assured that any serious risks in this site have mitigation strategies in place as per the Remote supervision risk management template. It may be that during discussions about risk management planning it is deemed that the training site is not appropriate for remote supervision at this time. In some areas, the community may require more discussion about a remotely supervised registrar, and the RACGP regional or local team will need to advocate across the community with their concerns.

Although accreditation of a remote supervision training site and accreditation of the remote supervisor are separate processes, it is important that potential supervisors are identified and engaged early on to ensure the supervisors are appropriate and the model of remote supervision can be confirmed well in advance of the placement commencing. It is also preferable that the remote supervisor is involved in the selection of the registrar.

Onsite supervision team

Clinical supervision when the supervisor is not always onsite requires a team approach. When the supervisor is offsite, the role of those working onsite with the registrar becomes more important. It is recognised that supervision to enhance learning is complex,[22] and that a strong relationship with an onsite multidisciplinary supervision team will assist learning within the different domains of clinical practice.

Rural and remote locations often have a skilled team of onsite nurse practitioners, remote area nurses and other staff. For some registrars, working in this context may require a changed mindset, moving away from hierarchical thinking. The supervisor has an important role in orientation to establish a strong working relationship with such a multidisciplinary team.

A typical onsite supervision team for remotely supervised placements will be multidisciplinary and involve three to four key people. The make-up of the team will depend on the type and size of the service and could include:

- the practice manager
- a nurse
- an Aboriginal health worker/practitioner
- a hospital doctor or local GP, if present
- a cultural mentor
- allied health professionals
- administrative staff.

The team members should be aware of potential conflicts of interest between their support roles for the registrar and other roles, such as being a colleague or manager.

The purpose of the onsite supervision team is to:

- ensure that registrars working in rural, remote and isolated locations have support and guidance that enables safety for themselves, patients and staff, as well as an environment for learning and growth
- provide a basis for effective communication and relationships between the registrar, local staff and patients, as well as with other health professionals attending the clinic
- collaborate with the remote supervisor in risk mitigation and management
- facilitate ad hoc reflection and debriefing in conjunction with the remote supervisor if required.

Establishing this team may require appropriate education or professional development and discussions to ensure the onsite team understands the role of the registrar and remote supervisor.

This will need to be relevant to the background of each onsite team member. It should be focused on the establishment and growth of working relationships, the purpose of the training term and partnership development. It is expected that the relationships between the registrar and this team will have a significant impact on learning opportunities, and ultimately the success of the term.

One member of the team will be nominated as the team lead and will be the remote supervisor's main point of contact. The team will meet every one to two months, depending on the registrar's term, usually connecting remotely with the remote supervisor.

Whenever there is discussion or communication between remote supervisors and the onsite team, it should be clear that there may need to be a response to the communication, involving the registrar. It should also be clear to the registrar that people will be 'talking about them' as well as talking with them.

Although some locations have a high staff turnover, a nominated onsite team, even with changing personnel, can work to ensure that the registrar is supported and that ongoing learning is enabled. The team will function more as a network with an 'inner core' of stable and regular members and external supports who will be called upon when needed.

Wider local, community and external supports

Although not part of the formal supervision team, other options for support will depend on the location. Relevant supports and escalation pathways should be identified prior to the placement and documented and discussed with the registrar during their orientation period.

Additional supports could include:

- the closest referral hospital or health service able to continue or escalate care, or able to give verbal advice
- rural training hubs
- Royal Flying Doctor Service/CareFlight/retrieval services
- district medical officer/remote medical practitioner
- visiting specialists
- a backup supervisor if the remote supervisor is not available
- IT support linked to the health service for the registrar and supervisor for communication issues, remote access and other software and hardware issues
- regional primary health network or state rural workforce agency

- local HealthPathways web-based portal
- online community of practice for appropriate and mediated support.

The remote supervisor

Remote supervisor expectations

Remote supervision is more complex than face-to-face supervision and, as such, requires significant supervision experience to be safe and effective. It is expected that a remote supervisor will be able to:

- understand the complexities of remote supervision and the requirements to do it safely and effectively
- develop and maintain the remote supervisor–registrar relationship
- effectively use technology in clinical supervision, teaching and communications
- provide proactive as well as reactive remote supervision
- develop connection with the onsite supervisory team and local community
- complete registrar assessments and provide effective feedback remotely.

The remote supervisor will visit the training site at specified times, will have regular communication with the registrar and will provide advice regarding clinical issues and other work-related concerns, as well as other professional support and mentoring. The remote supervisor will ensure that appropriate feedback is given about the progress of the placement to the registrar, the RACGP and the clinic.

In addition, the remote supervisor will:

- ensure they have regular 'quarantined' time for teaching with the registrar
- ensure they are available for ad hoc clinical advice whenever the registrar is working, or organise another appropriate GP to be available, communicating this arrangement to the registrar and onsite team
- follow clear guidelines about the management of significant issues regarding the registrar, and be able to escalate support appropriately
- ensure the onsite supervision team has appropriate expectations, and establish and respond to ongoing communication with that team.

Clinical responsibility while supervising remotely is the same as traditional face-to-face supervision and, as such, the requirements for medical indemnity are the same.

Remote supervisor eligibility

Supervisors interested in remote supervision will need to be accredited as a remote supervisor. In addition to meeting the standard RACGP supervisor accreditation requirements, a remote supervisor is required to have:

- experience and competence as a supervisor
- current and/or previous working experience in the proposed location or similar
- capacity to be available and to travel to the location as required
- the ability to use practice software and to manage connectivity
- creativity and commitment to provide high-level remote support.

Identification of potential remote supervisors will be a collaborative effort between the remote supervision team and the regional and local teams. Potential supervisors to consider include:

- supervisors recommended by the local team who have recently left the training site of interest
- supervisors who have previously (recently) worked at the training site of interest
- supervisors nearing retirement and who have flexibility and availability as required
- GPs who have worked in the location as locums and who have the necessary skill set
- supervisors without necessary experience who could work with a more experienced supervisor.

Other possibilities could include those taking family leave and doctors who have expressed interest and have been directed to gain locum experience at the proposed site.

Remote supervisor accreditation

The accreditation of remote supervisors follows the same process as standard supervisor accreditation as per the National Accreditation Framework with additional criteria and activities specific to remote supervision. These include submitting a curriculum vitae (CV) and a cover letter outlining their interest in becoming a remote supervisor, completing the Remote supervisor accreditation requirements document and meeting each of the criteria listed in that document.

The accreditation process includes an informal interview with the remote supervision team to determine whether the supervisor has the capacity, willingness and skills to provide quality supervision, understands the remote supervision guidelines and requirements, and is willing to work with the RACGP local team and onsite supervision team.

Remote supervisors are also expected to complete the Introduction to Remote supervision in general practice training online module in gplearning. This module covers the following topics:

- the registrar–remote supervisor relationship and education alliance
- technology and communication
- proactive and ad hoc remote supervision
- remotely conducted assessments and feedback
- remote community connections.

Contextualised remote supervision placement process

The supervisor contextualised remote supervision placement process (CRSPP) interview is a discussion designed to ensure suitability for the training site and the model of remote supervision. The supervisor will be required to participate in a CRSPP interview for each new location to ensure they are appropriate for the context at that time and are a good fit for the particular registrar. The interview will identify any areas of skill development that may be required before or during the training term. It is important that the remote supervisor understands the local context that the registrar will be working in, and has the ability to respond appropriately to the needs of the registrar. The remote supervisor must be committed to the process and understand the challenges and risks associated with the individual training site.

For experienced remote supervisors, the interview will be used as a basis for reflective discussion and review of previous supervision, as well as a means to determine whether further preparation or training is helpful. If the supervisor is new to remote supervision, the accreditation interview and CRSPP interview will be combined.

The CRSPP interview for supervisors should be conducted by an RACGP medical educator and a representative from the training site, and the Remote supervisor interview outcomes document completed.

The Remote supervisor interview guide provides the interview structure and questions, as well as

suggested scenarios to discuss, including the potential supervisor's strengths and weaknesses, anticipated challenges and how they will address them, and potential areas for upskilling.

The scenarios will explore what the supervisor would do if they had a registrar who was:

- highly anxious
- clinically unsafe
- identified as having an issue with substance abuse
- unprofessional
- not accepting feedback
- having personal problems
- kept the supervisor 'out of the loop' of what was happening in the clinic
- culturally inappropriate.

Potential outcomes and recommendations of the interview include, but are not limited to:

- appropriate for the training site and to supervise the registrar assigned to this site
- recommended to upskill in a certain area prior to this particular placement (eg IT, cultural training relevant to the local area)
- co-supervise with an experienced remote supervisor
- recommended to complete a short locum position at the proposed site or participate in a site visit to get to know the community
- complete training modules such as those developed by Remote Area Health Corps (RAHC) to enable supervision in a geographically remote area
- not appropriate for this training site at this time or suitable for a different training site
- not appropriate for remote supervision at this time.

Remote supervisor support

A community of practice between remote supervisors will be established and will provide opportunities to share experiences and help with problem solving. It could be facilitated by the remote supervision team, or remote supervisors may choose to connect independently. Such a community of practice can also support a supervisor who might have particular problems such as IT or supporting a registrar in difficulty. The 'tips and tricks' from such a group will be invaluable, and there will be accountability and support of each other.

The registrar

Registrar eligibility

Registrars interested in undertaking a remotely supervised term should meet the following criteria:

- GPT2+ with the appropriate skill level, competence and experience to work in the chosen location; GPT1 registrars may be considered in some circumstances if they have significant prior experience and robust support
- willingness to work remotely in a team environment within the constraints of the particular location
- attributes such as awareness of personal limitations, the ability to accept and use feedback and good communication skills, which will be important for the success of the remote supervision process
- ability and willingness to use IT resources to enable remote support.

The Remote supervision registrar requirements document outlines the registrar requirements in more detail.

Registrar selection: CRSPP interview

Purpose

The registrar CRSPP interview is designed to assess the registrar's flexibility, cultural awareness, teamwork skills, willingness to learn and ability to accept and implement feedback. It is not expected that the registrar will have detailed knowledge of the context of the potential placement location because it is unlikely that they will be familiar with it.

During the interview, a series of case scenarios relevant to the context of the training site will be used to help explore areas that may require skill development, including cultural understanding and attitudes, clinical expertise and readiness to work with a team in a remote location.

The interview will review the registrar's current clinical skills and those required for the new location, the thought processes behind their decision making in the scenarios, their personal resourcefulness, their insight into their own knowledge and skill gaps and how they ask for help. It will also identify areas that may need some upskilling before their placement.

The registrar CRSPP interview is not an examination about clinical skills, but more a discussion about the context of the placement and the attitudes and skills needed to work there. The scenarios may appear challenging, but they are designed to look particularly for the registrar's approach to these issues. There will also be an opportunity to consider assessments of previous registrar placements, particularly in ensuring resilience and initiative. The aim is to ensure that the registrar is suitable for the planned placement.

The interview should not be seen as a barrier, but rather as an opportunity to identify and address gaps in the registrar's skills.

Interview

The interview panel is made up of three interviewers: an RACGP medical educator, the remote supervisor (if known) and a senior member of the onsite supervision team.

General questions for the registrar include a discussion of the registrar's strengths and weaknesses, anticipated challenges and how they will manage them and areas they may requiring upskilling in prior to the placement.

There are nine scenarios that are basic stems that will need to be contextualised to the training site. Not all will be used. Issues addressed in the scenarios include:

- local health infrastructure and resources for issues that may more commonly occur locally

- cultural awareness and appropriateness
- ethical and legal implications and boundary issues in a small community
- awareness and ability to address mental health, social issues, drug-seeking triage and emergency skills
- resourcefulness and problem solving
- ability to accept feedback
- insight into gaps and asking for help appropriately
- dealing with uncertainty, safety netting and follow up
- managing issues with other staff.

Please refer to the Registrar CRSPP interview guide for examples of scenarios to be adapted to the local situation and context.

Interview scenarios are not confidential. Prior to the interview, these scenarios will be adapted and contextualised to be relevant to the training location by the remote supervisor or training site representative. This could occur in discussion with the interview panel immediately before the interview.

During the interview each panel member will document their notes in the Registrar CRSPP interview outcomes document.

Outcomes

Following the registrar interview, the panel will convene to make a recommendation on the outcome of the CRSPP. This will include a review of the registrar's CV, previous workplace-based assessments and other information from previous placements. Recommendations could include:

- upskilling before the placement (eg emergency skills, palliative care, drug and alcohol, mental health, practical or procedural skills)
- a 'call for help' list tailored to the registrar in this placement, where the registrar needs to discuss cases on the list with the supervisor, either at the time of the patient presentation or at the end of the day, until the supervisor is confident the registrar can ask for assistance 'as needed'
- the registrar needs more face-to-face supervision before they are ready for remote supervision
- facilitating a site visit for the registrar, if necessary, prior to committing to the placement
- the registrar is not appropriate for this training site at this time and will require another placement location (the registrar may be encouraged to undertake a general practice placement under a normal supervision arrangement and reapply)
- the registrar needs to establish specific skill/knowledge during the orientation period while working with the supervisor onsite.

For those deemed appropriate, the process is concluded with starting to develop the Remote supervision placement plan and a contextualised 'call for help' list. The Remote supervision placement plan is developed to finalise the details of the placement for approval by the lead medical educator remote supervision and relevant state censor.

It is important to note that even if the registrar is successful and placed in the remotely supervised training site, the two-week orientation period when the remote supervisor is onsite with the registrar should be seen as a type of 'probationary' period to fully assess whether remote supervision is appropriate in this context (refer to Remote supervision orientation).

The supervisor–registrar relationship

The supervisor should ensure that learning is not limited to clinical skill development, and should incorporate all aspects of professional development required in general practice. Research identifies four domains that represent the perceived interpretation of learning-focused clinical supervision:[21]

- **Domain 1: To partner** – establish relationships, develop common views about the purpose and process of the supervision
- **Domain 2: To nurture** – aid transitioning and socialising the registrar into the new learning context and establish their position as part of the team
- **Domain 3: To enable** – recognise, promote and encourage opportunities for engagement in healthcare provision
- **Domain 4: To facilitate meaning** – guide the registrar's understanding of how educational and clinical worlds combine in importance, application and relevance to practice.

A relationship of respect, trust and a strong educational alliance are of the utmost importance in the remote situation because the supervisor will need to 'find the truth' about how the registrar is progressing.[23]

The supervisor needs to be able to trust that the registrar has the knowledge and skills needed for the context in which they are working and that they have insight into those situations when they need to ask for feedback or assistance. A 'call for help' list or the use of entrustable professional activities (EPAs) will assist with assessing the need for supervision with various activities.[24,25]

As one of the stakeholders said, 'As trust increases, the level of intervention of the supervisor decreases.'

The initial orientation period is an important time to develop the supervisor–registrar relationship. Remote supervision is unlikely to be successful if a good relationship is not built up with the initial face-to-face contact. The establishment of such an educational alliance based on mutual respect will facilitate learning.

The remote supervisor will behave more as a 'coach', encouraging the registrar to explore the clinical reasoning behind decisions rather than immediately providing answers. Such 'coaching' of the registrar, including promoting self-reflection on knowledge gaps, attitudes and beliefs that may impact on patient care, is likely to be more difficult remotely.[5]

Useful tools include the General practice supervisory relationship measure (supervisors) and General practice supervisory relationship measure (registrars).

The face-to-face orientation period enables the registrar and remote supervisor to:

- become familiar with each other's skillset, knowledge base and communication style
- learn each other's subtle and non-verbal cues, which may be difficult to pick up online
- become familiar with strengths and weaknesses well enough to nurture growth and development
- begin to develop a two-way relationship where the supervisor openly discusses with the registrar how their own backgrounds and assumptions are translating into their work as clinicians
- establish and develop a relationship of trust and respect that is important for sensitive and appropriate support while the supervisor is off-site.

If the registrar–supervisor relationship is not supportive, particularly in serious or emergency situations, the registrar should discuss this with their medical educator, the RACGP local training coordinator or a clinical teaching visitor.

Orientation onsite

Remote supervision orientation requires the registrar and remote supervisor to spend the initial one to two weeks of the placement together in a mostly supernumerary capacity, preferably at the training site. The aims of this orientation period will require clear communication with the training site staff prior to the orientation time, because local expectations may be centred on opportunities for increased clinical work opportunities.

There is some flexibility in how the orientation is structured, and it should be tailored to suit the needs of the training site, registrar and remote supervisor. The remote supervisor and registrar should spend **at least** one week together, and the remaining orientation could be conducted by other members of the onsite team as deemed appropriate.

There is also flexibility to reduce the period of orientation if the registrar and remote supervisor already have a strong working relationship, or if the registrar has extensive remote supervision experience. If face-to-face orientation is reduced, it is expected that the registrar and remote supervisor speak daily to build their relationship and discuss patients for at least the first two weeks.

A good orientation takes time and organisation. Some activities can be done by the practice manager and other members of the onsite supervision team; however, the supervisor should take a primary role and must be involved with teaching how to use the clinical software and in the rehearsal of emergency procedures, as well as in discussions about teaching and supervision.

The remote supervision orientation guidance document and checklist has been developed to support practices and remote supervisors plan and provide a comprehensive orientation. This document is designed to be downloaded, edited and contextualised to the training site.

Outcomes of the face-to-face orientation period

- Clearly defined expectations, roles and responsibilities
- Clear instructions for the multidisciplinary onsite supervision team
- A Remote supervision risk management plan with mitigation strategies documented
- A tailored clinical supervision plan and call for help list
- Scheduled supervision times in advance as appropriate
- Escalation and emergency planning and pathways
- Confirmation that the workplace, contracts and facilities are appropriate and suitable for the registrar
- Mutual understanding of the complexities and the breadth and depth of support that is needed in that particular context
- Established communication processes and mutual willingness and ability to communicate effectively online
- Encouragement for the registrar to join an online community of practice with other registrars in similar contexts
- In rare situations, it may become clear that the registrar is not appropriate to continue at this training site at this time

Remote supervisor responsibilities during orientation

- Observe the registrar consulting to assess performance, any unconscious lack of awareness of gaps and the questions they ask and do not ask, so as to assess the appropriateness of their help seeking

- Discussion of complex local case scenarios, referral pathways, procedural skills, cultural issues, point-of-care investigations, communication style, follow-up processes, liaison with the team on the ground, escalation and emergency protocols
- Discussion and support not just about clinical education, but also about non-clinical issues, such as management, administrative issues, billing, internal political issues, patient advocacy, public health concerns and personal, social and emotional aspects of life in a small community
- Development of the local supervision team to clarify expectations and roles, to establish methods of giving and receiving feedback and to reinforce the value of this team to the success of the training term
- Assisting connection between the registrar and the community, with support from the local cultural advisor if appropriate

If the registrar does not feel supported by the remote supervisor, they are unlikely to be comfortable in calling for help or in acknowledging their clinical, educational and personal areas of need.

As a previously remotely supervised registrar who was interviewed for this project said:

> **[I want to speak to]** *someone I know and trust … you know that they're responsible and reliable and care about what you're doing … and they know a bit about me and my limits.*

Orientation to the community

Community engagement is fundamental to a successful remote supervision placement. The community needs to be engaged with the registrar and they need to be integrated into the community to understand the contextual, cultural and nuanced needs of that community.

It is important to have the community engagement led by a community ambassador and supported by a cultural advisor, if the training site is within an Aboriginal or Torres Strait Islander community or a site with predominance of other cultural groups.

Orientation to the community should include:

- the local supervision team and other health professionals in the area
- clinic operations and procedures
- other healthcare facilities (eg hospital, aged care)
- wider local services or resources that can be accessed
- meeting with local community members so that the registrar has a clear understanding of various roles in the community; this may include:
- local paramedic/s
- local pharmacist
- community elders
- local council mayor
- orientation to community and cultural issues by a local cultural advisor
- local social, education institutions, sporting teams, activities, religious institutions, calendar of events
- listed resources that outline the history and features of the location, if available.

Establishing a clinical supervision plan

Orientation of the registrar also involves giving clear information and discussing about how remote supervision and teaching will happen throughout the term. This includes:

- How and when to ask for help – a 'call for help' list should be agreed to and formalised during orientation and then reviewed regularly
- The arrangements for backup supervision if the usual supervisor/s is/are non-contactable
- Early discussion of learning needs and a plan to address them
- Formal, scheduled teaching – how and when it will happen
- Opportunistic teaching from questions or cases
- How assessments will happen remotely, including direct observation and clinical case analysis
- Feedback – what it looks like and how it happens. The registrar should be encouraged to develop a trust relationship with the onsite supervision team that allows feedback in an appropriate and constructive manner.

All registrars should be made aware that it is an expectation that they seek advice as much as they require. This may involve reassuring them of the supervisor's willingness and availability to help.

These arrangements should be discussed with everyone in the onsite supervision team, and relevant aspects communicated with the whole practice.

These arrangements should be formalised in a Clinical supervision plan.

Risk assessment and management

Risk assessment and management is an integral part of a remote supervision placement to ensure the safety of the patients, the registrar, the remote supervisor, the training site and the community. Although any clinical experience learning placement has risks, the potentially higher level of risks with the distance factor added means that a more stringent risk management approach will be needed for remote supervision terms. Risks must be identified, and the strategies to prevent and control each risk should be documented, with resources available for these strategies to be implemented if necessary. It is recognised that medical practice will never be risk free, but that careful consideration of possible risks associated with remote supervision and practice can assist with risk mitigation.

The Remote supervision risk management plan template is designed to be downloaded and completed by the training site and remote supervisor. Risk categories include environmental and training site risks, registrar risks, training risks and risks to the supervisor–registrar relationship.

The Remote supervision risk assessment and management – examples is a completed version of the template and provides risks, potential consequences and mitigation strategies that may be considered to help plan for each remote supervision placement. It is important for the training site to develop its own risk management plan using the template, contextualising the items so the plan is relevant to the site.

The remote supervision risk management plan needs to be started by the training site during the accreditation process to identify any red flags that need to be addressed early on. The plan is then completed during the orientation period by the remote supervisor in consultation with the training site and the registrar. It is important that the risks and mitigation strategies are discussed with the registrar and reviewed throughout the duration of the training term. Completion of the risk management plan will not only identify issues that need to be addressed early in the placement, but will also serve as a resource for future placements.

Safety for patients is the ultimate goal of training, encompassing all of the risk categories, and will include:

- safety – registrar selection, monitoring of registrar–supervisor interaction and good project management
- quality care – supervisors' availability, approachability, backup arrangements and willingness to be called whenever needed
- emergencies and escalation pathway – this is an essential activity during the orientation period.

Emergency and non-emergency escalations during a remote supervision term

The remote supervisor must be made aware of all emergency situations as soon as practical, particularly as they are still medico-legally responsible for the registrar, as with traditional face-to-face supervision.

Initial management must be appropriate to the situation, and the registrar is expected to follow the local training site emergency and escalation policy. Collegial support in an emergency is different to supervision, and asking for the assistance of other health professionals is essential. Communication with the remote supervisor after an incident is required for debriefing and educational purposes.

In a serious but non-emergency situation, the registrar will discuss concerns with the remote supervisor, and together they can decide on further management. This may involve the onsite supervision team, the RACGP local medical educator or the RACGP regional team.

If at any point throughout the selection process or during the term there are serious safety or other concerns, the registrar will be supported to leave the placement and find alternative arrangements if necessary.

Preparing for emergencies

One of the main concerns of inexperienced doctors going to practise in areas where there is professional isolation is being required to treat a critically unwell patient on their own. The possibility of a poor outcome creates significant anxiety in all of us, but more so in a registrar with less experience. Anxiety can be mitigated, and patient safety improved, with appropriate preparation for such events. This begins during the application process and is reviewed carefully during orientation, involving the local supervision team. It is important that the registrar understands that they are part of a team in these events, and that clinic debriefing procedures are understood and followed.

There are three important aspects of preparing for an emergency clinical scenario:

1. Previous experience of the registrar

The registrar needs emergency training at a level appropriate for the placement, and the supervisor should be aware of gaps in the registrar's experience from the CRSPP, and additional training organised before the placement begins if this is necessary. When asked to be involved during an initial assessment and management of an acutely unwell patient, the level of assistance required should already be in the supervisor's mind. The available equipment should also be familiar to the supervisor, so that assistance can be specific to the context.

2. Emergency and escalation pathways

A clear pathway should be established with the onsite team and be documented in the orientation manual of what to do in an emergency or if escalation of a clinical situation is needed. When both doctors are in the clinic in the initial orientation period, there should be a run-through of cardiac, respiratory and trauma scenarios, involving adult and paediatric simulations, preferably with a local health professional who is part of the onsite supervision team also present. This scenario practise should involve a review of the onsite staff's level of experience, allocation of roles and, in particular, decisions about who should be leading the team. Knowledge of the clinical management required is part of this, but mainly the run-through is about knowing the equipment, who to call, initiating a video link and contacting appropriate specialists for input, as well as contacting the supervisor if appropriate.

If such an incident occurs while the supervisor is offsite and the registrar requires supervision, the best oversight is obtained by having a view of the resuscitation space via a video link. How this is possible in the context should be established during the orientation period and should be one of the initial steps in the emergency and escalation pathway. If communication can also be established with another clinician, such

as at the referring emergency department, clinical oversight can be transferred to the senior clinician in that facility.

It is likely that some emergencies will need direct support from the service that will transport the patient or receive the stabilised patient. In these situations, making contact with the supervisor simultaneously may be inappropriate. If this is the case, the supervisor should be contacted as soon as possible after patient stabilisation is achieved, and certainly for debriefing and discussion after the event.

Additional supports could include:

- the closest referral hospital or health service able to continue or escalate care, or able to give verbal advice
- Royal Flying Doctor Service/CareFlight/retrieval services
- district medical officer/remote medical practitioner
- visiting specialists
- a backup supervisor if the remote supervisor is not available
- IT support linked to the health service for the registrar and supervisor for communication issues, remote access and other software and hardware issues
- the regional primary health network or state rural workforce agency
- local HealthPathways web-based portal.

After hours:

Normally the remote supervisor would not be involved in after hours work. The local referral pathways should be used for emergencies during this time. A clearly defined process will be required for the registrar.

Hospital work:

Hospital work needs to be negotiated on a case by case basis.

3. Emergency procedures

There will be situations where a procedure is required as part of an emergency, such as insertion of a chest tube. If an emergency procedure is required as part of treating the acutely unwell patient, the risk assessment filter followed should include the following:

- Is completion essential NOW, before the arrival of an experienced retrieval doctor and additional equipment? Is there time to talk through the details prior to the procedure, or is it time critical requiring real-time teaching?
- What is the registrar's experience with this procedure? (Do not neglect the experience of a nurse in the clinic. They may have assisted with several such procedures and can perform it or guide the process.)
- What is your experience and competence with the procedure? Are you able to talk through the steps required competently and confidently?
- What is the advice of the specialist or emergency physician who will be managing ongoing care?

Communication and effective use of technology

In order to best manage the complexity of remote supervision, the registrar–supervisor relationship should be one of mutual respect and understanding between colleagues.

They will have a 'shared understanding of performance and standards, negotiating agreement on action plans, working together toward reaching the goals, and co-creating opportunities to use feedback in practice'.[26]

This 'educational alliance' will also involve the registrar looking for the supervisor's commitment to the training and their credibility as a clinician and an educator.[19] This also includes the 'nurturing' aspect of supervision, with an enthusiastic, open and collaborative registrar–supervisor relationship, including the 'recognition and response to emotional needs of the trainee'.[27]

Communication methods

Suggested communication methods, depending on the circumstance and purpose, include:

- regular, planned catch-ups via videoconference that are scheduled in advance
- telephone/video calls (eg FaceTime) to address urgent issues
- text, email or other agreed methods of communication for 'checking-in' or non-urgent issues.

Different technology will be used depending on the purpose of the communication. For example:

- daily 'check-in' may be by SMS
- quick ad hoc questions may be triggered by SMS and then a telephone call
- more complex questions may involve sending images and then may involve a videoconference
- three-way discussions with the registrar, supervisor and patient may occur using videoconferencing – this could include the supervisor watching a physical examination or having a discussion with the patient
- the supervisor can audit the registrar's notes, results or referrals using remote access to the clinical software
- the supervisor can directly observe the registrar's consultations using a videoconference log-in on a second device in the room while simultaneously accessing the registrar's notes, either using remote access or a screen-share function
- case-based discussions and random case analysis (RCA) can occur by telephone or videoconference with both the registrar and supervisor remotely accessing a patient's files or using a screen-share function.

Clinical activities while remote

Providing digital images or clinical photography is valuable to allow the remote supervisor to make their own clinical judgement on patient presentations. If digital images of any kind are used during remote supervision, the registrar and remote supervisor are both advised to follow the local medical service guidelines regarding digital photography and patient consent, as well as the RACGP's guidelines, Using personal mobile devices for clinical photos in general practice.

The following are also useful resources:

- the AMA guideline, Clinical images and the use of personal mobile devices
- the *Australian Journal of General Practice* article, Clinical photography of skin lesions: Professional and legal considerations in primary care.

The ability to look at the registrar's notes and see or talk to the patient if necessary is also beneficial for remote supervision. Remote access to clinical software is ideal, but sometimes not possible. A camera could be placed on a tripod in the consulting room that could be used to see the patient as well as the registrar's notes. The 'share screen' feature on platforms such as Zoom, GoToMeeting, WebEx, HealthDirect or Microsoft Teams can also be used to allow the remote supervisor to see the registrar's notes.

Equipment to support remote supervision

Training site equipment essential for a safe and effective remote supervision placement includes:

- webcam and headset
- two-screen option – a laptop, tablet computer, telephone or other portable device that can be taken to other rooms or placed elsewhere in the clinic
- phone stand
- an IT equipment system compatible for the local/regional health referral system
- where internet connectivity is unreliable, the training site could consider arranging a Starlink package for the registrar (Starlink is a satellite system that delivers global internet coverage using a portable satellite dish mount and Wi-Fi router; https://www.starlink.com).

Additional equipment relevant to the context of the placement should be included in training site accreditation for remote supervision placements. Examples include:

- video-otoscope
- loupe
- dermatoscope
- appropriate equipment for ear canal foreign bodies (eg Jobson–Horn probe)
- sonosite ultrasound machine/bubble ultrasound, if deemed appropriate and depending on location
- other equipment required for solo extended scope of practice.

The remote supervisor will require:

- webcam and headset
- screen, tablet or laptop with a second screen.

Assessments in the context of remote supervision

Registrar assessments are completed as per their training program requirements. This section discusses considerations of assessments in the context of remote supervision.

Assessments of a registrar's progress and feedback about gaps and improvements are an integral part of training. For Australian GP registrars, the Fellowship exams can be used as reference points, but low stakes assessments, such as directly observed consulting, RCA, case-based discussions, workshops and other group educational activities, are essential as part of the RACGP progressive assessment framework and to ascertain whether a registrar is a safe and effective practitioner.[17]

In order for any assessment to be valid, the doctor doing the assessment must understand the context of the registrar's workplace. This is particularly true for remote assessments when the assessor cannot directly see the environment in which the registrar is working.

The initial face-to-face orientation period will assist the supervisor in ascertaining the supervision the registrar is likely to need in the future, to build up a relationship with the registrar and to discuss how feedback will be given when the supervisor is remote. Further face-to-face periods of time throughout the term will also strengthen this.

If a supervisor is worried about a registrar's progress in a face-to-face situation, they will usually choose to spend more time with the registrar. There will be an escalation process in place for registrars who are flagged or need remediation, but ascertaining the need for further input will be done after more information is gleaned.[23]

The use of IT to 'Zoom in' to the registrar's consulting room can overcome some of the barriers to assessments, coaching and giving feedback. Some supervisors actually find this more useful than face to face because they can see what the registrar is writing in the notes, for example if they have a remote desktop access to the patient's file in addition to the videoconference into the consultation.

The experience of one registrar exemplifies how this can be successful:

> *Sometimes they will be [a long way away] and they would web zoom into my consult room and I had a little camera on top of my computer and they could see me and the patient.*
>
> *So they would just sit there muted and with my camera on in the background and watch me with the consult, which is actually really fantastic because usually you'll have people that come in and watch you observe your practice and they'll be sitting in your room and kind of make you feel uncomfortable.*
>
> *This is great, because no one else was in the room, and it worked really well and it was a mix of getting direct feedback from consultations that I had, RCAs … and then if I wanted to learn more, it was what I wanted to do. Or whether the supervisor thought that I had a gap in my knowledge to focus on those kind of areas, so it was a mix of things.*

Another advantage of videoconference-based assessments is the cost saving on travel for the supervisor or medical educator. Despite many assessments being undertaken remotely, all should still fulfil the requirements of the RACGP progressive assessment framework.

How assessments can be done remotely by the supervisor or medical educator

- Remote supervisor observation of consultations using the registrar's computer or another online camera in the room
- Remote observation of registrar consultations with the ability to simultaneously watch them make notes in the patient file
- Focused observation of consultations, which may be a Mini-Clinical Evaluation Exercise (MiniCEX), where the supervisor and registrar agree that the supervisor will focus on giving feedback on a particular issue (eg body language, open-ended questions, safety-netting, communication skills)

- RCA where both the registrar and supervisor have access to the clinical software
- Case-based discussions where the registrar presents a case of their choosing
- Review of investigation ordering, referrals and prescribing where both the registrar and supervisor have access to the clinical software
- Discussions with the onsite supervision team about the registrar's competence
- Role-playing, particularly for mental health issues, domestic violence, drug and alcohol, motivational interviewing for chronic disease management or ethical dilemmas
- Review of 'call for help' list or EPAs[25]

External clinical teaching visits

External clinical teaching (ECT) visitors will need to have a thorough understanding of the guidelines, especially because they will be assessing the risk management plan and the utility of the onsite supervision team.

The following questions should be asked during an ECT visit at a remote supervision site:

- Do you think you have adequate access to your supervisor?
- Has the onsite supervision team been useful?
- Has the risk management matrix identified and mitigated any risks you have encountered?
- Has the contextualised remote supervision plan helped you identify gaps and issues?

Registrar support

Safety and wellbeing

One of the greatest risks for remote supervision is the isolation. In addition to being a clinical risk, it is also a personal and social risk. A registrar who is feeling isolated is more likely to become stressed, overwhelmed and burnt out.

As well as support from the remote supervisor, the onsite team, the practice and the community, the RACGP will ensure there are adequate support and safety-net structures around the registrar when they are working remotely from their supervisor. A peer group of other registrars who are remotely supervised will give opportunities for debriefing and a discussion of challenges and how they have been addressed in different contexts.

Other supports and resources include:

- regular meeting with the RACGP local training coordinator
- community of practice with other remotely supervised/local registrars (eg special interest groups, peer support groups, formal 'buddy' arrangements)
- cultural support through the RACGP and cultural mentors
- RACGP White Book, 5th edition – Chapter 8: The doctor and the importance of self-care
- Drs4Drs
- Hand-n-Hand – a peer support service for health professionals in Australia and New Zealand.

Professional development

Prior to starting their remote supervision placement, the registrar will be supported by the RACGP to address gaps identified in the CRSPP, or to facilitate specific training to meet the needs of the training site community. Training needs may include:

- basic radiography
- ultrasound training
- emergency skills
- chronic disease management
- palliative care
- drug and alcohol skills
- education in local illness profiles, such as hepatitis B.

The registrar will be required to have sufficient skills to effectively engage with their supervisor remotely. Professional development should include:

- effective use of technology
- clinical photography
- how to develop and maintain an effective education alliance.

Remotely supervised registrars are encouraged to undertake self-directed learning and engage in a community of practice with other registrars to facilitate peer learning. Professional development relevant to working in rural and remote areas is encouraged and includes:

- public health knowledge and skills
- development of leadership, advocacy and interprofessional skills.

Useful clinical resources for remotely supervisor registrars include:

- Murtagh General Practice, 8th edition
- The Medical Board, Good Medical Practice
- Electronic Therapeutic Guidelines
- Australian Medicines Handbook
- UpToDate
- Central Australian Rural Practitioners Association, Standard Treatment Manual
- Remote Area Health Corps
- TeleDerm
- DermNet
- DynaMed

Funding for remote supervision

Adequate funding for GP supervision in Australia has been debated for many years. Supervisors are usually committed to supervision because they want to pass their knowledge and skills on to the next generation, because they enjoy the relationship with younger doctors as it gives them renewed energy for the profession, because they are hoping that registrars will continue to work in their practices or because having a varied work portfolio improves their wellbeing and decreases their risk of burnout. In addition, being adequately paid for their time will decrease their risk of burnout because the supervisors will feel valued by the organisation they are working for, in this case the RACGP.

In order to acknowledge the important work that remote supervisors are undertaking, in the formal, ad hoc, leadership and mentoring roles they play, an increased pay schedule has been negotiated. This will vary depending on the registrar, the placement and the requirements, according to the principles below.

Remote supervision activities that need to be funded

The following activities will need to be contextualised to the needs of the training site, the supervisors and the registrar experience, and paid accordingly:

- remote supervision orientation onsite, plus travel and accommodation for remote supervisor
- weekly remote supervision time
- mid-term site visit, plus travel and accommodation for remote supervisor.

Who funds these remote supervision activities will vary depending on the registrar's training program and the training site's eligibility for additional government funding. Training sites that are not eligible for Federal Government funding may still be able to use the guidelines and fund the costs themselves, or other sources of funding may be investigated.

General remote supervision funding principles

- Every placement is different and needs to be assessed on a case-by-case basis.
- Registrar safety and a quality training experience are paramount.
- If the registrar is part-time, orientation and weekly remote supervision should be pro rata.
- Remote supervisors should not 'double dip' for payments during the onsite orientation period. They should be paid to be mostly supernumerary with the registrar.
- The training site/community is encouraged to provide the registrar and supervisor accommodation where possible.
- At least one mid-term site visit should be arranged per term. Where possible, the mid-term supervisor site visits should be combined with locum visits, ECT visits or other activities when the supervisor will be nearby or onsite.
- Where possible, encourage one-year placement because the second orientation period will not be required.

Evaluation of remote supervision placements

The remote supervisor, training site and registrar will be required to participate in the evaluation of remote supervision placements to ensure the models are refined and that the registrars have a safe and high-quality experience.

The approach for evaluation of remote supervision placements is outlined in the RACGP education and training monitoring and evaluation framework. Evaluation questions relating to remote supervision placements include:

- Has the remote supervision placement achieved comparable outcomes to onsite supervision?
- Did the registrar, supervisor, training site and patients feel safe?
- Was the placement educationally sound, resource-efficient and budgeted appropriately?
- Were the registrar and supervisor appropriately assessed and selected for the local context?
- Was there adequate community engagement?
- Were risks identified and managed appropriately?
- How do supporting components of remote supervision (ie weekly teleconference, designated contact hours with remote supervisor, peer support groups, teaching time, orientation period) contribute to the placement? Do they need to be altered to be more effective?
- Would the registrar, remote supervisor and training site recommend remote supervision for future placements? If not, what needs to be improved or changed?
- Is remote supervision feasible and sustainable in this location?

References

1. Young L, Peel R, O'Sullivan B, Reeve C. Building general practice training capacity in rural and remote Australia with underserved primary care services: A qualitative investigation. BMC Health Serv Res 2019;19(1):338. doi: 10.1186/s12913-019-4078-1.
2. Australian Institute of Health and Welfare (AIHW). Rural and remote health. AIHW, 2022. Available at www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health [Accessed 9 March 2022].
3. The Royal Australian College of General Practitioners (RACGP). General practice: Health of the nation 2019. RACGP, 2019.
4. Harrison C, Britt H. General practice – workforce gaps now and in 2020. Aust Fam Physician 2011;40(1–2):12–15.
5. Wearne SM. Is it remotely possible? Remote supervision of general practice trainees [PhD thesis]. Maastricht University, 2015. doi: 10.26481/dis.20150408sw.
6. Wearne SM, Teunissen PW, Dornan T, Skinner T. Physical isolation with virtual support: Registrars' learning via remote supervision. Med Teach 2015;37(7):670–76. doi: 10.3109/0142159X.2014.947941.
7. Varela SM, Hays C, Knight S, Hays R. Models of remote professional supervision for psychologists in rural and remote locations: A systematic review. Aust J Rural Health 2021;29(2):211–25. doi: 10.1111/ajr.12740.
8. Hays RB. Remote supervision of health professionals in areas of workforce need: Time to extend the model? Rural Remote Health 2012;12:2322. doi: 10.22605/RRH2322.
9. Australian Medical Council (AMC). Standards for assessment and accreditation of specialist medical programs and professional development programs by the Australian Medical Council 2015. AMC, 2015. Available at https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf [Accessed 3 July 2023].
10. Worley PS, O'Sullivan B, Ellis R. From locum-led outposts to locally led continuous rural training networks: The National Rural Generalist Pathway. Med J Aust 2019;211(2):57–59.e1. doi: 10.5694/mja2.50225.
11. Wearne S. Remote supervision during general practice training. Educ Prim Care 2016;27(4):333–34. doi: 10.1080/14739879.2016.1207103.
12. Kanakis K, Young L, Reeve C, Hays R, Gupta TS, Malau-Aduli B. How does GP training impact rural and remote underserved communities? Exploring community and professional perceptions. BMC Health Serv Res 2020;20(1):812. doi: 10.1186/s12913-020-05684-7.
13. Thomson JS, Anderson KJ, Mara PR, Stevenson AD. Supervision – growing and building a sustainable general practice supervisor system. Med J Aust 2011;194(11):S101–04. doi: 10.5694/j.1326-5377.2011.tb03139.x.
14. Wearne SM. In-practice and distance consultant on-call general practitioner supervisors for Australian general practice? Med J Aust 2011;195(4):224–28. doi: 10.5694/j.1326-5377.2011.tb03288.x.
15. Wearne SM. Remote supervision in postgraduate training: A personal view. Med J Aust 2013;198(11):633–34. doi: 10.5694/mja13.10296.
16. Ingham G, Fry J. A blended supervision model in Australian general practice training. Aust Fam Physician 2016;45(5):343–46.
17. Wearne S, Dornan T, Teunissen PW, Skinner T. Twelve tips on how to set up postgraduate training via remote clinical supervision. Med Teach 2013;35(11):891–94. doi: 10.3109/0142159X.2013.805878.
18. Hays R, Peterson L. Distant supervision in training for remote medical practice. Educ Gen Pract 1997;8:123–27.
19. Moran AM, Coyle J, Pope R, Boxall D, Nancarrow SA, Young J. Supervision, support and mentoring interventions for health practitioners in rural and remote contexts: An integrative review and thematic synthesis of the literature to identify mechanisms for successful outcomes. Hum Resour Health 2014;12(1):10. doi: 10.1186/1478-4491-12-10.
20. Bayley SA, Magin PJ, Sweatman JM, Regan CM. Effects of compulsory rural vocational training for Australian general practitioners: A qualitative study. Aust Health Rev 2011;35(1):81–85. doi: 10.1071/AH09853.
21. Pront L, Gillham D, Schuwirth LW. Competencies to enable learning-focused clinical supervision: A thematic analysis of the literature. Med Educ 2016;50(4):485–95. doi: 10.1111/medu.12854.
22. Campbell N, Wozniak H. A guide to creating a culture of quality supervision: work-based peer review of clinical supervision practice. Greater Northern Australia Regional Training Network with Flinders University, 2014., Available at www.flinders.edu.au/content/dam/documents/research/prideaux-research-health-professions-education/peer-review-resources/peer-review-guide-enhance-clinical-supervision.pdf [Accessed 3 July 2023].
23. Wearne SM, Dornan T, Teunissen PW, Skinner T. Supervisor continuity or co-location: Which matters in residency education? Findings from a qualitative study of remote supervisor family physicians in Australia and Canada. Acad Med 2015;90(4):525–31. doi: 10.1097/ACM.0000000000000587.

24. Ingham G, Plastow K, Kippen R, White N. A 'call for help' list for Australian general practice registrars. Aust J Gen Pract 2020;49(5):280–87. doi: 10.31128/AJGP-07-19-4997.
25. Valentine N, Wignes J, Benson J, Clota S, Schuwirth LW. Entrustable professional activities for workplace assessment of general practice trainees. Med J Aust 2019;210(8):354–59. doi: 10.5694/mja2.50130.
26. Telio S, Ajjawi R, Regehr G. The 'educational alliance' as a framework for reconceptualizing feedback in medical education. Acad Med 2015;90(5):609–14. doi: 10.1097/ACM.0000000000000560.
27. Costello S, Benson J, Burns J, Bentley M, Elliott T, Kippen R. Adaptation and initial examination of the psychometric properties of the Short Supervisory Relationship Questionnaire (SSRQ) for use with general practice registrars. Educ Prim Care 2020;31(6):341–48. doi: 10.1080/14739879.2020.1806114.

Appendix 1: Guideline development

The Australian Department of Health and Aged Care funded two projects to develop, pilot and refine the remote supervision guidelines in 2021–23:

- Remote Supervision for Rural and Remote Practices project (2021–22)
- Remote Supervision pilot project (2022–23)

Remote supervision for rural and remote practices project

The purpose of the Remote Supervision for Rural and Remote Practices project was to develop a model for GP registrars working at sites where remote supervision is needed in order to ensure safe and effective training, education and support.

Although funded and developed within the RACGP, the ***Guidelines for safe and effective general practice training utilising remote supervision*** have been written to be applicable beyond the Australian General Practice Training (AGPT) program, and are relevant to all doctors training in general practice and working in locations needing remote supervision, regardless of the training program.

A remote supervision expert advisory group (EAG) with a diverse range of remote supervision experiences was formed. This group included academics, previously remotely supervised registrars, remote supervisors and key stakeholders. Their advice was sought at both formal meetings and on an ad hoc basis.

An extensive review was undertaken, exploring both national and international literature on remote supervision for doctors, as well as for other health professionals. Some of the authors of seminal articles were contacted in order to access older articles, for advice about other literature related to the topic and to take part in the interviews. Recommendations of articles also came from the interview participants.

A document review and environmental scan explored documents from regional training organisations (RTOs) and other organisations, and included:

- past evaluations of remote supervision models
- templates for use in remote supervision
- outlines of models
- guidelines for remote supervision
- conference presentations
- newsletter articles.

Further grey literature was discovered from searches, as well as being submitted by interviewees.

Semistructured interviews were conducted with over 50 relevant stakeholders. Initially this was strategic, with known experts, those recommended by the EAG, RTOs, other key stakeholder organisations and authors of relevant literature. This then proceeded into an iterative snowballing process, where interviewees recommended others to be interviewed, contributed documents and suggested peer-reviewed literature.

The final interview list included:

- academics
- authors of relevant literature
- current and past remotely supervised GP registrars

- current and past remote supervisors
- current and past RTO directors of training and education
- medical educators
- administrators of remote supervision models
- CEOs of relevant organisations (eg General Practice Supervisors Australia, Remote Vocational Training Scheme)
- developers of remote supervision models for other health professions
- experts in Aboriginal and Torres Strait Islander health
- health professionals administering other models (eg Practice Experience Program, More Doctors for Rural Australia Program)
- medico-legal experts
- representatives from the RACGP, Australian College of Rural and Remote Medicine and the Australian Medical Council, regarding administration, new models, evaluation, financing, medico-legal issues and internal political issues.

Questions were asked about the interviewees' particular area of expertise, then more generally about remote supervision, including:

- models of remote supervision that have been tried or are currently in use
- the strengths and weaknesses of these models
- the potential for adding medical graduates to areas of workforce need
- risks in remote supervision and ways to mitigate potential risks
- the acceptance of remote supervision by rural and remote communities.

The transcripts from the interviews, peer-reviewed literature, grey literature and relevant documents were triangulated using NVivo to develop an approach to the remote supervision guidelines.

Eighteen themes were identified from the 130 documents analysed. These were then discussed within the project team and with the EAG. The rich data that ensued from this process informed the development of such novel procedures as the contextualised remote supervision placement process (CRSPP), the models of supervision, the risk management matrix and the remote assessment options. The final document has undergone several rounds of review by the EAG and other key stakeholders.

A formative evaluation approach was embedded throughout the initial development of the remote supervision guidelines. The scope of this evaluation focused on formative considerations to assess project planning, progress, operational processes and short-term outcomes.

Remote supervision pilot project

The remote supervision pilot project implemented and evaluated the remote supervision guidelines, as well as the associated documents and processes, to refine the guidelines prior to wider implementation.

After the implementation and evaluation of the remote supervision in the two pilot training sites (Norfolk Island and in the Aboriginal Medical Service in the rural New South Wales town of Walgett), the registrars have chosen to continue working in both these locations as Fellowed GPs after completion of all their training requirements. Both locations were considered areas of workforce need, and without remote supervision would not have been able to have a registrar work in their health service. To have the GPs continue to work in these sites is testimony to the success of the supervision, support and processes implemented through the remote supervision guidelines.

The pilot project aimed to evaluate the various processes, including:

- training site accreditation with remote supervision risk assessment
- registrar and remote supervisor eligibility and selection requirements
- establishing an onsite supervisory team
- remote supervision orientation period
- remote supervision throughout the placement.

Interviews were undertaken with the registrars, supervisors and representatives from the training sites at three points in time: before the placement commenced, after orientation and in the final weeks of training. The operational staff involved in the placements were also interviewed about whether the documents and procedures were practical, timely and facilitated streamlined processes throughout the pilot. All participants were asked whether they would recommend any changes or do anything differently in future remotely supervised placements.

The evaluation was overwhelmingly positive, with very few changes recommended, and most of these minor. As well as the registrars continuing on in the locations in which they trained, they both said that remote supervision was 'better than any face-to-face supervision' they had ever had. The three supervisors are also very keen to continue to remotely supervise GP registrars, and the training sites would like remotely supervised registrars again in the future. Findings from the evaluation have been used to revise the guidelines and associated documentation and processes.

Appendix 2: RACGP remote supervision documents and forms

Remote supervision snapshot

Requirements for accreditation as a remote supervision training site

Remote supervisor accreditation requirements

Remote supervisor interview guide

Remote supervisor interview outcomes

Remote supervision registrar requirements

Registrar CRSPP interview guide

Registrar CRSPP interview outcomes

Remote supervision placement plan

Remote supervision risk management plan template

Remote supervision risk assessment and management – Examples

Remote supervision in-practice orientation guidance document and checklist

Clinical supervision plan

Call for help list

General practice supervisory relationship measure (registrars)

General practice supervisory relationship measure (supervisors)

Appendix 3: Remote supervision placement example

Example of how the remote supervision guidelines have been applied.

Context/location	Aboriginal Medical Service, Modified Monash Model (MMM) 6
Selection and accreditation process	Training site was previously accredited for general practitioner (GP) training, but previous supervisors left. No regular onsite GP at the time, and the site had not had a registrar in a number of years. Training site accredited for remote supervision. Two supervisors who had previously worked at the training site or worked as locums engaged and accredited for remote supervision. Registrar and supervisors participated in contextualised remote supervision placement process (CRSPP) to confirm suitability for remote supervision and to conduct gap analysis.
Model of remote supervision	Fully remote supervision
Remote supervisor/s	1 × primary remote supervisor 1 × secondary remote supervisor Shared supervision and teaching responsibilities
Registrar GP term	GPT3
Orientation period	Two weeks face-to-face orientation for the registrar. Each remote supervisor conducted orientation for one week. Each supervisor had a different focus based on their expertise and familiarity with the practice. One remote supervisor focused more on clinical supervision activities and the other focused more on clinic and community orientation. Both supervisors had a Medicare provider number (MPN) for the practice and were able to consult with the registrar during orientation. Orientation included: • development of a 'call for help' list and supervision plan • building an education alliance between both supervisors and the registrar • development of an onsite team and introduction into the community • establishing escalation and emergency procedures • establishing communication channels and plans for how they will communicate in different situations • arranging scheduled times in advance • consultation observation.

Onsite team	• Practice manager • Aboriginal health practitioner • Chronic disease manager • Cultural mentor • Regular locums and remote area nurses The primary remote supervisor had regular contact with the onsite team to monitor registrar progress.
Site visit	Site visit planned mid-term, but was rescheduled and then cancelled due to flooding. Registrar progress and safety were assessed and extended virtual meetings were conducted in place of the site visit. An additional external clinical teaching visit was conducted by a medical educator.
Funding	The practice was in an MMM6 location and was identified as an area of workforce need, so was eligible for Australian General Practice Training program flexible funds for remote supervision at that time.
Evaluation	The registrar enjoyed placement and felt well supported. The registrar continued in the same location under the same model of remote supervision for GPT4.

Healthy Profession.
Healthy Australia.

RACGP