

GUIDELINES FOR COLLEGE-DIRECTED SUPERVISION

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS / HEALTHY SYSTEM / PUBLIC TRUST

The College of Physicians and Surgeons of Ontario

Guidelines for College-Directed Supervision

Background

Within medical practice, various forms of supervision exist for all physicians; by local institutional structures, group practice accountabilities, employer-employee relationships, or the overarching accountability within the professional regulatory framework. The nature, level, frequency and duration of the supervision can vary significantly depending on the specific circumstances involved. Physicians may be supervised as they re-enter practice after an absence, during the transition to a new scope of practice, when relocating to Ontario from another jurisdiction, or as a result of competence concerns following an assessment or investigation. Supervision is often graded, i.e. the level of supervision may be decreased gradually resulting in ultimate removal of the supervisor and the return of the physician to full independent practice. In other cases, the level of supervision may always remain consistent and in fact, may never cease. The best interests of the patients must always be the first and foremost consideration – particularly, in any decisions around establishing or modifying supervision arrangements.

Scope

These Guidelines are directed at supervisors and supervised physicians who are participating in a supervisory arrangement that is borne out of a College process. The Guidelines are not intended for medical students or postgraduate medical trainees. The College's documents entitled "Professional Responsibilities in Undergraduate Medical Education" and "Professional Responsibilities in Postgraduate Medical Education" address supervision issues related to students and postgraduate medical trainees.

Purpose

The purpose of these Guidelines is to provide a general overview to supervisors (prospective and confirmed) and supervised physicians of their individual roles and responsibilities/obligations to each other, as well as to the College when participating in a supervisory arrangement. Any parties officially entering a supervisory arrangement would be asked to sign formal written detailed agreements setting out the College's specific expectations. The role of the supervisor will vary according to the needs or goals of the supervision arrangement. For example, a supervising physician may be required to oversee a physician's progress in a training program to ensure s/he meets certain learning objectives. In other instances the supervising physician may be required to monitor a physician's practice to ensure that the physician is limiting his/her practice to previously identified parameters. The section on 'Definitions' will define the different types of supervisory roles.

Therefore, these Guidelines will identify the College's expectations for each type of supervisory arrangement in respect to:

- Characteristics necessary to serve in the supervisory role;
- Core responsibilities associated with each supervisory role;
- Additional responsibilities that may be associated with the role - which are related to the Department/Committee that directs the supervision;
- Core expectations of the supervised physician; and,
- Additional expectations of the supervised physician.

Principles of Supervision

The principles for supervision are as follows:

1. The best interests of the patient are central to all physician-patient interactions.
2. The practice of medicine is inherently uncertain and there is a level of risk associated with all patient care decisions. Risk is reduced through the proper application of knowledge, skill and judgment.
3. Respect for the autonomy and personal dignity of patient and physician optimizes patient care as well as the supervisory experience.
4. Clear delineation of the most responsible physician, decision-making and exchange of information between supervisor and physician will obtain the best results from the supervisory experience.
5. Physician improvement (practice relationships, enhanced clinical skills) is facilitated by their active involvement in the provision of health care with hands-on delivery in a system of delegated and graded responsibility.
6. Physician health is an important factor in enabling the delivery of quality care to patients.
7. There is an expected standard of care associated with each discipline or specialty of practice.

When applied in a consistent and responsible manner, supervision will ensure quality physicians and public trust.

Definitions

Most Responsible Physician (“MRP”) is the physician who has final responsibility and is accountable for the medical care of a patient.

Supervision is the act of overseeing any combination of the following: work, health status, and continuing professional development of a physician. The level of oversight may be defined as low, moderate or high. The nature, frequency, level and duration of interaction between supervisor and supervised physician will depend on the specific goals or objectives of the supervisory arrangement.

Mentor is a member of the CPSO who serves to guide the physician through the health care system in Ontario. The mentor is available to provide advice on how to deal with clinical and other practice concerns. A mentor does not have an obligation provide supervision reports to the CPSO, as this individual is not considered a supervisor, as defined in these Guidelines, but may sometimes augment other types of supervision arrangements. At minimum, there is a requirement that the member is not currently the subject of any disciplinary or incapacity proceeding. The member’s history with the College would also be considered.

Supervisors are individuals who are approved by the College to oversee the work, health status, or continuing professional development of a physician. Most often, supervisors are physicians, but in some cases, they may be other health professionals who are fulfilling special duties for the College.

The term supervisor is sometimes used interchangeably with practice monitor, preceptor, or mentor, which can lead to confusion about the role of the supervisor. Therefore, for the purpose of this document, whenever the term “supervisor(s)” appears, it is being utilized in a general sense, i.e. to refer collectively to all types of supervisors. For clarity, however, the following terms are used to distinguish between the different types of supervisory roles:

Part A: Clinical Preceptor – refers to an individual who serves as a “clinical teacher”, i.e. to guide, observe and assess the educational activities of a physician. This role typically involves assisting the physician in the initial development of an educational plan with specified learning objectives for the supervised timeframe. The *Clinical Preceptor* is then required to review and report on a physician’s progress in a training program, i.e. ability to meet learning objectives, to the College. There may be expectation for direct observation, on-going feedback/evaluation to the supervised physician, as well as providing advice on continuing professional development.

Part B: Clinical Supervisor – refers to an individual who inspects a physician’s practice at regularly prescribed intervals set by the College to ensure that the physician is meeting the expected standard of care and that patient safety is not being compromised. The *Clinical Supervisor* identifies physician enhancement opportunities to the supervised physician. He or she may also assist physician in learning about community resources to help meet patient needs.

Part C: Practice Monitor – refers to an individual who is responsible for ensuring that the physician is in compliance with the provisions of his/her undertaking or order, or the terms and conditions imposed by a Committee upon the physician’s certificate of registration. This individual, who is not always a physician (but will generally be a member of another health regulatory college), confirms that the physician is restricting or modifying his or her practice according to such pre-defined terms. The terms of the physician’s undertaking or order, or the terms and conditions imposed upon the member’s certificate of registration are made in response to the determination that the physician’s practice or conduct falls below the standard, constitutes incompetence or professional misconduct, and possibly poses a risk of harm to patients.

Part D: Health Monitor – refers to an individual who is treating a supervised physician for particular health issues. This individual, who is not necessarily a physician (e.g. psychotherapist, etc.) is required to report to the College on a regular basis, as well as when the physician is not complying with treatment recommendations, and/or when the physician’s health may be affecting his/her ability to practise safely. A large proportion of physicians being monitored for health purposes are monitored through the Physician Health Program of the Ontario Medical Association (the PHP). In such cases, and when the physician has had College involvement, the PHP is considered the *Health Monitor*, and reports regularly to the College.

Supervisor Serving in More Than One Role

The sections that follow provide an overview of the different types of supervisory arrangements, including the desired characteristics of the supervisor, as well as responsibilities of both supervisor and supervised physician. However, it should be noted that in some cases, where required and appropriate, the College may ask a supervisor to take on responsibilities that are a blend of two types of supervisory roles. The College would make this clear to the supervisor when defining the parameters of his/her role.

RISK ASSESSMENT AND ESTABLISHING AN EFFECTIVE SUPERVISION PLAN

Assessment of Risk and Establishing the Level of Supervision Required

Supervision is necessary when there is a level of risk to patient safety that is over and above the inherent level of risk of practising medicine. There are various risk factors that impact patient safety and thereby, necessitate supervision. On a general level, supervision may be required due to a physician's incomplete qualifications, demonstrated deficiencies as determined by assessment or a pattern of conduct or behaviour that is by all accounts unacceptable, but potentially remediable. The College expects that there will be a level of oversight to ensure appropriate patient care until education and improvement adjust the risk factors.

The College is responsible for establishing the **initial** level of risk to patient safety, and also identifying the initial level of supervision required for the supervisory arrangement. However, in supervisory arrangements involving a *Clinical Preceptor* or *Clinical Supervisor*, the supervisor is expected to closely evaluate the physician's performance at the start of the supervision period, so that he or she is able to define strengths and weaknesses from the onset of supervision. Therefore, the level of supervision may be modified further according to the outcome of this evaluation phase. Where such supervision is mandated by a College committee such as the Complaints, Executive, Discipline or Fitness to Practice Committees (and, as of June 4, 2009, the Inquiries, Complaints and Reports Committee), any adjustments to the level of supervision may need to be approved by the originating Committee.

Identifying the Goal of the Supervision Arrangement

As a first step, the College would identify the goals of the supervisory arrangement:

- To prepare the doctor for the completion of qualifications;
- To provide educational or remedial programs in order to address the physician's identified clinical deficiencies;
- To ensure that the physician is practising safely and within parameters identified by the College;
- To ensure that the physician's health status is not affecting or interfering with his or her ability to practice safely.

Once the goal of the supervisory arrangement is established, there are a number of detailed risk factors that would be considered within the context of the physician's circumstances. The relevance of the factors will vary according to the specific goals of the supervision arrangement, however, the risk factors fall into the following two key categories -

1. The Physician's Situation

- What is the physician's training experience?
- What amount of independent practice experience does the physician hold?
- Has s/he been engaged in meaningful CPD?
- What is his or her age?
- Are there any existing restrictions on the physician's current certificate? What type of certificate of registration (licence) does the physician hold?
- Is there a history of clinical performance, conduct or capacity issues?
- What qualifications, if any, is the physician lacking?

- If the physician is newly registered with the College, is his or her scope of practice in Ontario comparable to his/her scope of practice in the preceding jurisdiction?
- If the physician is newly registered with the College, does the physician have some or no experience in the Canadian context?

2. The Scope of the Physician's Practice

- Will the physician still be the *most responsible physician* throughout the supervised period with full and direct responsibility for decisions about patient care?
- Is the physician's training and experience commensurate with his or her continued scope of practice?
- What is the practice environment – office, institutional, community?
- Is the physician practising in a remote, rural or urban situation?
- Will there be local supports or resources available to the physician? For example, will consultants be available? Does the physician have a base of supportive colleagues and co-workers who are committed to his or her safe practice?
- Will the physician be accountable to others within an institutional framework (Head of Department, Chief of Staff, etc.)?
- What are the patient demographics, conditions, acuity, etc.?
- Will the patient population be medical or surgical?
- How many patient visits per week does the physician manage?
- Does the physician practise a specialty with potential for immediate and serious consequences to patient safety (surgery, anaesthesia, cosmetic surgery, etc.)?

In addition to the above risk assessment process, the College would also rely on the clinical judgment and experience of College Committee members who undertake a detailed review of the physician's situation and establish the level of supervision required for a physician. In some instances, the Committee may also have specific policies that have bearing on the physician's situation and therefore, these would need to be considered when making decisions about supervision. Therefore, a formal risk analysis coupled with Committee members' clinical judgment and experience enables the College to arrive at decisions regarding an overall level of supervision - low, moderate, or high, required for the physician, as well as how that supervision needs to be conducted.

Definitions of Levels of Supervision

The level of supervision required – low, moderate, or high translates directly into specific College expectations about the features of the supervision arrangement:

- the component/tools of supervision to be used by the supervisor;
- availability of the supervisor;
- autonomy of the physician, and;
- frequency of the supervisor's reporting to the College.

The definitions of low, moderate and high supervision have been identified in the Clinical Preceptorship and Clinical Supervision sections. Levels of supervision have not been defined levels of supervision for Practice Monitoring and Health Monitoring as these forms of supervision are individualized according to the circumstances presented.

The sections that follow will describe the supervisory role, as well as the College's expectations around the supervision levels associated with each role.

Part A – Clinical Preceptorship

A *Clinical Preceptor* is responsible for guiding, observing and assessing the educational activities of a physician. S/he, along with the help of College staff, assists the physician in the development of an educational plan, which includes identifying specific learning objectives for the training phase. In some cases, a College Committee may have indicated specific educational courses or programs, which would be integrated into the member's educational plan. The *Clinical Preceptor* is then required to review and report on a regular basis to the College on the physician's progress in the program. The *Clinical Preceptor* may be expected to provide direct observation, on-going feedback/evaluation to the supervised physician, as well as advice on continuing professional development, if indicated.

The goal is to assist the physician in acquiring or improving their knowledge and/or clinical skills with the intent of preparing the physician to work independently in that area of practice. The content of the training program could be very focused or broad in nature – it depends on the specific needs of the physician.

Supervision is generally graded. Initially, the *Clinical Preceptor* is often required to directly observe patient care in order to determine the physician's level of knowledge and clinical skills, and thereby, identify his/her specific needs. Thereafter, the physician's responsibilities are increased in a graduated manner commensurate with the knowledge and clinical skills that s/he is able to demonstrate to the *Clinical Preceptor* as he or she progresses through the program.

A Clinical Preceptorship most often involves a 'team-based approach', that is, more than one *Clinical Preceptor* participates in guiding the educational activities of the physician. In this case, all members of the team must be formally approved by the College. One physician is designated as the 'lead preceptor' and serves as the **primary contact** for the College. S/he is expected to do the following: appropriately delegate some responsibility to other team members along with clear instruction about the supervision protocol to be used, e.g. tools, format of supervision, etc.; solicit feedback on a regular and ongoing basis from team members; ensure steady communication exists amongst team members to properly monitor the physician's progress, and; submit interim and final reports to the College which must sufficiently reflect observations and assessments of the **entire** team. Depending on the circumstances, a Clinical Preceptorship could take place at more than one site with a different 'lead preceptor' to be designated at each site.

The approximate duration of the program is typically pre-defined by the College based upon the identified needs of the physician, but may be adjusted i.e. lengthened or reduced by the College, depending on the physician's performance as he or she completes the program.

Physicians are encouraged to actively participate in finding a potential *Clinical Preceptor*. However, the College ultimately approves the *Clinical Preceptor*.

Characteristics of an Acceptable Clinical Preceptor (College staff may exercise discretion)

- Ontario registration for independent practice;
- Practises in Ontario;
- Minimum of five consecutive years in practice in the scope of the practice to be supervised – may include same functional specialty;
- At minimum, member is not currently the subject of any disciplinary or incapacity proceeding. Member's history with the College would also be considered;
- Member of the CMPA or otherwise having valid and adequate liability protection as defined in Section 50.2 of the College's General By-Law;

- Willingness to comply with all terms of the College agreement;
- Able to provide constructive/honest feedback to physician and College;
- Experience in, or willingness to learn about, the education and evaluation of practising physicians;
- Affiliations with relevant institutions in the community of practice;
- Strong sense of professional responsibility and commitment to peer support;
- Active in continuing professional development;
- No real or perceived conflict of interest; if in doubt, discuss with College staff.

Core Responsibilities of a Clinical Preceptor

- Review any pertinent background materials about the physician's practice as provided by the College;
- May assist the physician, with the help of a Medical Officer or College staff, in the development of an educational plan with specified learning objectives;
- If a 'team approach' is taken, the 'lead preceptor' must clearly identify all *Clinical Preceptors* to the College for approval, and ensure that input/feedback is obtained from all team members when preparing interim and final reports.
- Identify and address other learning opportunities during the course of the supervision period;
- Provide direct and immediate feedback to the physician that is constructive, objective and honest;
- Establish a supportive, collegial and professional relationship with the physician to facilitate success;
- Maintain appropriate boundaries with the physician, respecting the role of the supervisor as an agent of the College;
- Be aware of real or perceived biases in relationship with physician;
- Provide quality reports at prescribed intervals, which reflect the content expected by the College;
- Verify that physician practises only in approved setting and context;
- Attend in person at the physician's practice to verify that patient care provided by the physician meets the expected standard of care by using the following tools (and others as deemed appropriate) -
 - Directly observing patient care, where appropriate;
 - Reviewing a selection of patient charts on a regular basis as prescribed by the College;
 - Discussing any concerns arising from the such chart reviews with the physician;
 - Making recommendations to the physician for practice improvements, and
 - Making recommendations to the physician for ongoing professional development and making inquiries with the physician to determine compliance or follow-up;
- Report immediately to the College any dangerous or unsafe practices which may put patients at risk, or any apparent breaches by the physician of his or her obligations to the College;
- Notify the College if unable to continue in the role.

Expectations of Physician Requiring Preceptorship

- Acknowledges that deficiencies have been identified in their practice;
- Motivated to, and takes responsibility for, improvement;
- Develops an educational plan with the assistance of Medical Officers or College staff, as well as the *Clinical Preceptor* to focus on identified learning objectives as defined, including clear identification of all *Clinical Preceptors* if a 'team approach' is taken and provide this information to the College;
- Respect for the interests of patients and their appropriate care and treatment;
- Open and honest with his or her colleagues and *Clinical Preceptor* to facilitate the educational and supervision process;
- Actively participates in all educational and practice activities that will lead to independent practice;
- Respect and collegiality towards the *Clinical Preceptor*;
- Ensures that required meetings with *Clinical Preceptor* are carried out and on time;
- Ensures that reports to the College are timely as per requirements;
- Demonstrates meaningful signs of progress towards meeting College expectations;

- Acknowledges that they are responsible for payment of all fees, costs, charges, expenses, etc. arising from the supervision arrangement;
- Gives irrevocable consent to the College to provide any background information that is pertinent in order to enable the *Clinical Preceptor(s)* (if more than one – i.e. ‘team approach’) to carry out their duties effectively and sufficiently informed;
- Agrees to information sharing amongst the *Clinical Preceptors* (if more than one), the College, and if applicable, with the *Clinical Supervisor(s)*.

Additional Committee-specific Expectations for Physician Requiring Preceptorship

Complaints/Executive/Discipline/Fitness to Practise/Inquiries, Complaints and Reports Committees

– The following additional responsibilities apply if the physician’s need for supervised training is the result of any such Committee’s direction –

- if the *Clinical Preceptor* is unable or unwilling to continue to fulfill the terms of their Undertaking, then the supervised physician is obligated to find a replacement to the best of his/her abilities from a similarly qualified person who is acceptable to the College and is not permitted to practice without a *Clinical Preceptor* in place.

Level of Supervision

The initial level of supervision will be directed by the College. However, the *Clinical Preceptor* is expected to closely evaluate the physician’s performance at the **start** of the supervision period, so that he or she is able to define strengths and weaknesses from the onset of supervision. Therefore, the level of supervision may be modified further according to the outcome of this evaluation phase.

The College, in some instances, may tailor the supervision, i.e. direct a “high” level of supervision for certain aspects of care where severe clinical deficiencies have been identified, while requiring only low or moderate supervision for other areas of practice in which less significant problems have been identified. Therefore, there may not be a uniform or consistent level of supervision for the entire Clinical Preceptorship.

In general, *Clinical Preceptors* should apply the principles of delegated and graded supervision when conducting supervision. While the College would broadly identify the educational needs of the physician (and may in some cases require specific education or training), it is the College’s expectation that the physician works closely with the *Clinical Preceptor* to develop an “educational plan” for the supervision phase. Physicians are encouraged to use the College’s Educational Template (see Sample Educational Template - Appendix 2) which requires the physician, with the assistance of the *Clinical Preceptor* to outline: educational needs, goals, proposed educational methods, assessment methods, and expected completion date in addressing each need for the supervision phase. In addition, the *Clinical Preceptor* might identify other “educational needs” during the course of the supervision, and these would need to be addressed as they arise. The completed Educational Template should be provided to the College for approval in advance of commencing the supervision phase. Medical Officers of the College are available to assist physicians and their preceptors in completing the Educational Template.

In situations where the physician is designated as requiring a “high” level of supervision, the physician will function initially at the level of a resident whereby he or she is **not** the MRP, i.e. the *Clinical Preceptor* takes full responsibility for management of patient care (see Table - below). As the physician makes meaningful progress towards meeting learning objectives specified in the Educational Template, then the *Clinical Preceptor* uses his or her discretion to recommend a reduction in the required level of supervision.

To ensure effective supervision, the *Clinical Preceptor* and physician must have a reciprocal relationship, i.e. the supervisor accepts responsibility to supervise the physician, and the physician accepts the responsibility of adhering to the educational plan and communicating all needed information to the supervisor. Supervision within the context of an educational program must adhere to the following basic principles:

1. Appropriate care of the patient is central to the training endeavour.
2. Proper training, which respects the autonomy and personal dignity of both patient and trainee, optimizes patient care as well as the educational experience.
3. In order to obtain the best results from the educational experience, there should be joint decision-making and exchange of information between supervisor and trainee.
4. Trainees must actively participate in the provision of health care in order to receive the training they require for future independent practice; that is, they must have hands-on experience in a system of delegated and graded responsibility. By doing, as well as observing, trainees learn how to question, examine, diagnose, manage, and treat patients, and adopt the necessary attitudes towards patients and their relatives, colleagues and other members of the health care team.

The *Clinical Preceptor* works with the physician within a system of delegated and graded supervision to facilitate the meeting of the educational needs outlined in the Educational Template. Outlined below are the College’s **minimum** expectations associated with each level of supervision, recognizing that source Committees/Departments could require the use of additional tools (see Appendix 2), etc.

Clinical Preceptor	Level of Supervision		
	Low	Moderate	High
<i>Components of Supervision – see Appendix 1</i>	<ul style="list-style-type: none"> • Chart reviews, with a focus on areas of identified need or concern • Weekly and eventually, monthly case discussions • Recommend CPD, as needed 	<ul style="list-style-type: none"> • Daily to weekly case discussions with the physician, sometimes immediately following patient encounter • Chart Reviews • Recommend CPD, as needed 	<ul style="list-style-type: none"> • Direct observation. • Discussions with physician immediately following patient encounters • Chart Reviews • Recommend CPD, as needed
<i>Availability of Clinical Preceptor</i>	Available by phone for consultation	Generally available in person	Available on-site with initial direct observation
<i>Autonomy of Physician</i>	Physician is the MRP	Physician is the MRP	Physician is not the MRP and functions at the level of a resident, while the Clinical Preceptor is the MRP
<i>Frequency of Reporting to the College</i>	Quarterly	Quarterly	Monthly

Modifying the Level of Supervision

It is important to note that if a physician's situation changes (the risk factors referred to above), the level of risk associated with his or her practice may also change. As the physician progresses through the supervision phase, supervisors must be cognizant of any such changes, which could impact patient safety. Supervisors are expected to report immediately to the College any dangerous or unsafe practices by the physician, or any apparent breaches by the physician of his or her obligations to the College.

The *Clinical Preceptor* uses his or her discretion to recommend a reduction in the required level of supervision. In situations where a physician commences the program with a "high" level of supervision, and is not the MRP, the decision to allow a physician to transition to a moderate level of supervision and thus to become the MRP will be made by consultation between the *Clinical Preceptor* and the College. In general, the level of supervision should be commensurate with the knowledge, clinical skills, and judgment that the physician is able to demonstrate to the *Clinical Preceptor* over time. There must be sufficient evidence collected through chart reviews, discussions with the physician, etc. that the physician is making meaningful progress towards meeting the learning objectives identified for the supervision phase before the level of supervision can be reduced.

The *Clinical Preceptor* may recognize strengths and weaknesses during the course of the supervision phase, and may suggest to the College modifications to the level of supervision for certain aspects of the supervision program, i.e. straddled system of supervision.

Ending the Supervision Phase

The timelines are always defined by the College. At the end of the supervision phase, the *Clinical Preceptor* would need to submit a final summary report to the College.

How Do We Know Whether Supervision has been Effective?

Depending on the physician's circumstances, the College *may* conduct re-assessment(s) or re-inspection(s) of the physician's practice during the course of the physician's educational program, and/or following completion of educational program. The College would also decide whether the goals of the supervision arrangement have been met. For example,

- Has the physician been able to successfully obtain missing qualifications?
- Did the educational program address the physician's identified clinical deficiencies?

The College would end the process by conducting a risk assessment, with patient safety being the primary consideration in relation to any further steps or decisions made by the College.

Part B – Clinical Supervision

A *Clinical Supervisor* is responsible for inspecting a physician's practice at regular intervals as prescribed by the College to ascertain whether the physician is practising safely and meets the expected clinical standard of care.

For instance, the physician may be lacking the usual qualifications to practice medicine in Ontario and therefore, has been granted provisional registration. In this case, clinical supervision is part of the terms and conditions imposed on the member's certificate and is required in order to assess the physician's competence and ensure that patient safety is not being compromised. Clinical supervision may also be necessary because the College has identified serious quality of care concerns in the physician's practice through an assessment. The College then needs to ascertain that the physician is practising safely and meets the expected clinical standard.

The length of time associated with the clinical supervision is usually pre-defined, and depends on the severity of the pre-identified deficiencies (i.e., whether they are clinical in nature, or the physician is missing qualifications) and may be adjusted by the College (lengthened or reduced) based on the reports submitted by the *Clinical Supervisor*.

Clinical Supervision may involve a 'team-based approach', that is, more than one *Clinical Supervisor* may participate in determining whether the physician is practising safely and meeting the expected clinical standard of care. In this case, all members of the team must be formally approved by the College. One physician is designated as the 'lead supervisor' and serves as the **primary contact** for the College. S/he is expected to do the following: appropriately delegate some responsibility to other team members along with clear instruction about the supervision protocol to be used, e.g. tools, format of supervision, etc.; solicit feedback on a regular and ongoing basis from team members; ensure steady communication exists amongst team members to properly monitor the physician's progress, and; submit interim and final reports to the College which must sufficiently reflect observations and assessments of the **entire** team. Depending on the circumstances, a Clinical Supervision arrangement could take place at more than one site with a different 'lead *Clinical Supervisor*' to be designated at each site.

The source Committee or Department will determine whether the physician is allowed to actively participate in finding a *Clinical Supervisor*.

Characteristics of an Acceptable Clinical Supervisor (College staff may exercise discretion)

- Ontario registration for independent practice;
- Practises in Ontario;
- Minimum of five consecutive years in practice in the scope of practice to be supervised – may include same functional specialty;
- At minimum, member is not currently the subject of any disciplinary or incapacity proceeding. Member's history with the College would also be considered;
- Member of the CMPA or otherwise having valid and adequate liability protection as defined in Section 50.2 of the College's General By-Law;
- Willingness to comply with all terms of the College agreement;
- Able to provide constructive/honest feedback to physician and College;
- Experience in, or willingness to learn about, the education and evaluation of practising physicians;
- Affiliations with relevant institutions in the community of practice;
- Strong sense of professional responsibility and commitment to peer support;
- Active in continuing professional development;
- No real or perceived conflict of interest; if in doubt, discuss with College staff.

Core Responsibilities of a Clinical Supervisor

- Review any pertinent background materials about the physician's practice as provided by the College;
- Provide direct and immediate feedback to the physician that is constructive, objective and honest;
- If a 'team approach' is taken, the 'lead supervisor' must clearly identify all *Clinical Supervisors* to the College for approval, and ensure that input/feedback is obtained from all team members when preparing interim and final reports.
- Establish a supportive, collegial and professional relationship with the physician to facilitate success;
- Maintain appropriate boundaries with the physician, respecting the role of the supervisor as an agent of the College;
- Be aware of real or perceived biases in relationship with physician;
- Provide quality reports at prescribed intervals, which reflect the content expected by the College;
- Verify that physician practises only in approved setting and context;
- Attend in person at the physician's practice to verify that patient care provided by the physician meets the expected standard of care by using the following tools (and others as deemed appropriate) -
 - Directly observing patient care, where appropriate;
 - Reviewing a selection of patient charts on a regular basis as prescribed by the College;
 - Discussing any concerns arising from the such chart reviews with the physician;
 - Making recommendations to the physician for practice improvements, and;
 - Making recommendations to the physician for ongoing professional development and making inquiries with the physician to determine compliance or follow-up;
- Report immediately to the College any dangerous or unsafe practices which may put patients at risk, or any apparent breaches by the physician of his or her obligations to the College;
- Notify the College if unable to continue in the role.

Core Expectations of the Clinically Supervised Physician

- Acknowledges that deficiencies have been identified in their practice;
- Gives irrevocable consent to the College to provide any pertinent background information to the *Clinical Supervisor(s)* (if more than one, i.e. 'team approach') so that they are sufficiently informed about the physician's situation in order to carry out their duties effectively;
- Motivated to, and takes responsibility for, improvement;
- Respect for the interests of patients and their appropriate care and treatment;
- Open and honest with his or her colleagues and *Clinical Supervisor* to facilitate the supervision process;
- Respect and collegiality towards the *Clinical Supervisor*;
- Ensures that required meetings with *Clinical Supervisor* are carried out and on time;
- Ensures that reports to the College are timely as per requirements;
- Demonstrates meaningful signs of progress towards meeting College expectations;
- Acknowledges that they are responsible for payment of all fees, costs, charges, expenses, etc. arising from the supervision arrangement;
- Agrees to information sharing amongst the *Clinical Supervisor(s)* (if more than one), the College, and if applicable, with the *Clinical Preceptor(s)*.

Level of Supervision

The initial level of supervision would be decided by the College. However, the *Clinical Supervisor* is expected to closely evaluate the physician's performance at the start of the supervision period, so that he or she is able to define strengths and weaknesses and how this may impact the level of supervision directed by the College. Therefore, the level of supervision may be modified further according to the outcome of this evaluation phase.

Clinical Supervisors are responsible for inspecting a physician’s practice at intervals prescribed the College to ascertain that the physician is practising safely and meets the expected clinical standard of care. Outlined below are the College’s expectations associated with each level of supervision, recognizing that source Committees/Departments could require the use of additional tools (see Appendix 2) -

Clinical Supervisor	Level of Supervision		
	Low	Moderate	High
<i>Components of Supervision – see Appendix 2</i>	<ul style="list-style-type: none"> • Chart reviews • Discussions with physician • Initially, limited direct observation, if directed 	<ul style="list-style-type: none"> • Chart reviews • Discussions with physician • Initially, limited direct observation, if directed 	<ul style="list-style-type: none"> • Direct and regular observation with Clinical Supervisor on site at all times until modified by CPSO • Chart reviews • Discussions with physician
<i>Availability and Frequency of Clinical Supervisor visits</i>	A few times every few months to inspect practice (preferably in person, unless otherwise specified by Committee)	Several times per month to inspect practice (preferably in person, unless otherwise specified by Committee)	Initially, available in person at all times; or otherwise, at least once per week to inspect practice
<i>Autonomy of Physician</i>	Physician is the MRP	Physician is the MRP	Physician is the MRP
<i>Frequency of Reporting to the College</i>	Every three to six months, or more frequently - depends on source Committee/Department	Approximately every three months, or more frequently - depends on source Committee/Department	Initially, a report is expected after the first month, and thereafter, frequency determined by source Committee/Department

Modifying the Level of Supervision

It is important to note that when the physician’s situation changes (the risk factors referred to earlier), the level of risk associated with his or her practice may also change. As the physician progresses through the supervision phase, the *Clinical Supervisor* must be cognizant of any such changes, which could impact patient safety. The *Clinical Supervisor* is expected to report immediately to the College any dangerous or unsafe practices by the physician, or any apparent breaches by the physician of his or her obligations to the College.

If the *Clinical Supervisor* believes that it is safe to lower the supervision level, then he or she would need to provide such information to the College for consideration, and include evidence that the physician is practising safely and meeting the expected clinical standard. Any modifications to the supervision level would generally need to be considered by the source Committee directing the supervision. In certain situations, staff may be able to exercise its discretion and approve the modification without requiring Committee approval.

Ending the Supervision Phase

The timelines are always defined by the College, however, clinical supervision would generally be expected to continue until there is a satisfactory re-evaluation of the physician's practice or until the source Committee lifts the supervision requirement. At the end of the supervision phase, the *Clinical Supervisor* would need to submit a final summary report to the College.

How Do We Know Whether Supervision has been Effective?

Depending on the physician's circumstances, the College *may* conduct re-assessment(s) or re-inspection(s) of the physician's practice during the course of the physician's supervision phase, and/or following completion of supervision. The College would also decide whether the goals of the supervision arrangement have been met. For example,

- Has the physician been able to successfully obtain missing qualifications?
- Has the physician been able to consistently meet the expected clinical standard of care?
- Is there sufficient evidence to demonstrate that the physician is practising safely?

The College would end the process by conducting a risk assessment, with patient safety being a key consideration in relation to any further steps or decisions made by the College.

Part C – Practice Monitoring

A *Practice Monitor* is responsible for ensuring that the physician is in compliance with the terms of his undertaking or order, or with the terms and conditions imposed by a Committee upon his or her certificate of registration. These roles have traditionally been referred to as “workplace monitors” or “chaperones”. The *Practice Monitor* signs an undertaking directly with the College. Depending on the situation, the *Practice Monitor* may not be a physician, but another Regulated Health Professional.

This supervisory arrangement is required in situations in which the physician has been required to restrict or modify his or her practice in some way. This supervision will generally take place in accordance with the provisions of an undertaking or order, or with terms and conditions imposed upon the member’s certificate of registration, when the physician’s practice and/or conduct has been determined to fall below the standard, constitute incompetence or professional misconduct, and possibly pose a risk of harm to patients.

Examples include:

(a) *The physician has been found incompetent by a Discipline Committee, on the basis that his/her opioid prescribing indicated a lack of knowledge, skill and judgment, and poses a risk of harm to patients.* In this situation, the Discipline Committee may require the physician to undergo education; obtain the co-signature of another physician on all opioid scripts; maintain a prescribing log; and undergo periodic practice re-inspections. These will be terms and conditions imposed upon the member’s certificate of registration. One *Practice Monitor* will be the physician responsible for co-signing opioid scripts. A second *Practice Monitor* will be the physician responsible for reviewing the standard of the physician’s opioid prescribing, and reconciling the physician’s log and patient records at various intervals.

(b) *The physician is alleged to have sexually abused a patient, and the alleged conduct has been referred to the Discipline Committee, and is of particular concern to the referring committee.* As a result, the Executive Committee (or, as of June 4, 2009, the Inquiries, Complaints and Reports Committee) may impose interim terms and conditions upon the member’s certificate of registration, pending the outcome of the Discipline matter. Such terms may prohibit the physician from dealing with specific categories of patients, e.g., females, without a “chaperone” (the historical term), and may require that the physician post a prominent sign in his/her office to that effect. In such cases, the “chaperone” will be the primary *Practice Monitor*, who may or may not be a physician.

(c) *The physician is applying for registration in Ontario. However, another provincial registration authority or a program director has expressed concerns about the physician’s conduct in relation to boundary issues.* On very rare occasions, the Registration Committee considers such applications and at times, there is insufficient evidence to completely refuse the application. The Committee may then issue a certificate of registration with terms and conditions attached, which requires the physician to always have a third party or “chaperone” present when seeing, for example, female patients and may require the physician to post a prominent sign in his/her office to that effect. In such cases, the “chaperone” will be the primary *Practice Monitor*, who may or may not be a physician.

(d) *The physician has entered into an undertaking with the College, in which he or she agrees to improve the hygiene and organization of his or her practice.* In this situation, the *Practice Monitor* may be required to inspect the physician’s practice at certain intervals, or on an announced basis, to ensure the physician is complying with the terms of his or her undertaking, and may or may not be a physician.

The source Committee or Department decides whether the physician may have input into the selection of a *Practice Monitor*. It is determined on a case by case basis.

Characteristics of an Acceptable Practice Monitor (College staff may exercise discretion)

- Ontario registration for independent practice if a physician; (generally, if not a physician, the *Practice Monitor* is a regulated health professional, such as a registered nurse or a pharmacist);
- Practises in Ontario;
- If specified, a minimum number of consecutive years in practice in the scope of practice to be monitored – may include same functional specialty;
- If a physician, at minimum, member is not currently the subject of any disciplinary or incapacity proceeding. Member's history with the College would also be considered;
- If a physician, the individual must be a member of the CMPA or otherwise having valid and adequate liability protection as defined in Section 50.2 of the College's General By-Law;
- Willingness to comply with all terms of his or her undertaking with the College;
- Able to provide constructive/honest feedback to physician and College;
- Experience in, or willingness to learn about, the education and evaluation of practising physicians;
- Affiliations with relevant institutions in the community of practice desirable;
- Strong sense of professional responsibility and commitment to peer support;
- Active in continuing professional development;
- No real or perceived conflict of interest; if in doubt, discuss with College staff.

Core Responsibilities of a Practice Monitor

- Review any pertinent background materials about the physician's practice as provided by the College;
- Maintain appropriate boundaries with the physician, respecting the role of the *Practice Monitor* as an agent of the College;
- Be aware of real or perceived biases in relationship with physician;
- Fulfill the specific requirements of his or her undertaking with the College;
- Verify whether the physician is practising in accordance with the terms of his or her undertaking or order;
- Provide quality reports at prescribed intervals, and as otherwise necessary, which reflect the content expected by the College;
- Provide immediate reports to the College if physician appears not to be complying with the terms of his undertaking or order, or if the physician's practice or conduct presents any concern to the *Practice Monitor*;
- Notify the College if unable to continue in the role.

Additional Committee-specific Expectations of a Practice Monitor

Complaints/Executive/Discipline/Fitness to Practise/Inquiries, Complaints and Reports Committees

– In some situations, where directed, a *Practice Monitor* is also required to review the physician's standard of care. Therefore, the role, at times, may extend beyond that of ensuring compliance with terms and conditions.

Expectations of the Monitored Physician

- Acknowledges that practice deficiencies or conduct issues have been identified;
- Respect for the interests and safety of patients, and their appropriate care and treatment;
- Open and honest with his or her colleagues and *Practice Monitor* to facilitate the supervision process;
- Respect and collegiality towards the *Practice Monitor*;
- Compliance with the terms of his or her undertaking or order;
- Demonstrates meaningful signs of progress towards meeting College expectations;
- Ensures that required meetings with *Practice Monitor* are carried out and on time;

- Ensures that reports to the College are timely as per requirements;
- Acknowledges responsibility for payment of all fees, costs, charges, expenses, etc. arising from the supervision arrangement;
- Gives irrevocable consent to the College to provide any background information that is pertinent in order to enable the *Practice Monitor* to carry out their duties effectively and with sufficient information;
- Agrees to information sharing amongst the *Practice Monitor(s)* (if there is more than one) and the College.

Level of Supervision

The level of supervision typically provided is moderate to high. It is not possible to set out expectations for low, moderate, or high levels of supervision for this type of supervision arrangement. The features of the supervision, i.e. components/tools to be used by the supervisor, availability of the supervisor, autonomy of the physician, and frequency of reports to the College are **uniquely** defined according to the specific circumstances of the physician.

Modifying the Level of Supervision

Practice Monitors are expected to report immediately to the College any dangerous or unsafe practices by the physician, or any apparent breaches by the physician of his or her terms and conditions, or other obligations to the College.

The monitored physician must request a variance to the undertaking or order. This request would need to be considered by the appropriate Committee (typically, Executive, Fitness to Practice, Discipline or Inquiries, Complaints and Reports Committees) and would require the written support of the *Practice Monitor*. It is worth noting that in some situations, the undertaking or order may include a condition that the physician cannot request a variance to the undertaking or order until a specified period of time has passed.

Ending the Supervision Phase

The timeline is always defined by the College. Any decision to altogether cease the monitoring arrangement would rest with the source Committee, directing the monitoring. In some instances, monitoring may remain consistent, and in fact, may never cease.

How Do We Know Whether Supervision has been Effective?

Depending on the physician's circumstances, the College *may* conduct re-assessment(s) or re-inspection(s) of the physician's practice during the course of the physician's practice monitoring and/or following completion of practice monitoring. The College would also decide whether the goals of the monitoring arrangement are being met and whether practice monitoring should continue. Patient safety is the key consideration in relation to any further steps or decisions made by the College.

PART D – HEALTH MONITORING

A *Health Monitor* is responsible for treating a supervised physician for particular health issues. This individual, who is not necessarily a physician (e.g. psychotherapist, etc.) is required to report to the College on a regular basis, as well as when the physician is not complying with treatment recommendations, and/or when the physician's health may be affecting his/her ability to practice safely.

The College is involved in the monitoring of members with all manner of health conditions which may affect their practices, including physical conditions such as Parkinson's disease or dementia; substance use disorders; and mental health conditions such as depression or schizophrenia.

A large proportion of physicians being monitored for health reasons by the College are monitored through the Physician Health Program of the Ontario Medical Association (the PHP); specifically, at present, those physicians who have been diagnosed with substance use disorders or Axis-1 mental health conditions (from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)). In such cases, the PHP oversees and manages the physician's health care and practice monitoring. The PHP then reports to the College on a regular and as-needed basis. Other types of health monitoring are conducted directly by the College. The duration and frequency of such health monitoring is determined by the College.

Generally, the physician will have input into the selection of a *Health Monitor*.

Characteristics of an Acceptable Health Monitor (College staff may exercise discretion)

- Must be a physician who holds Ontario registration for independent practice, and practises in Ontario OR a member of another regulated health profession who is acceptable to the College.
- If a physician, at minimum, member is not currently the subject of any disciplinary or incapacity proceeding. Member's history with the College would also be considered;
- If a physician, the individual must be a member of the CMPA or otherwise have valid and adequate liability protection as defined in Section 50.2 of the College's General By-Law;
- be a member of the CMPA or another provider of protection for professional liability;
- Must have at least 5 years of clinical experience in providing health care in the area of the health monitoring;
- Willing to comply with all terms of the College agreement;
- Able to provide constructive/honest feedback to physician and College;
- Affiliations with relevant institutions in the community of practice;
- Strong sense of professional responsibility and commitment to peer support;
- Active in continuing professional development;

Core Responsibilities of a Health Monitor

- Review any pertinent background materials about the physician's practice as provided by the College;
- Agrees to see the physician professionally at regular intervals as specified by the College. Also, during vacation or other absence, will make arrangements for the necessary health care to continue to be provided by another health therapist;
- Monitor the physician's compliance with the treatment regime;
- Report immediately to the College –
 - the physician is acting in a manner that suggests that s/he may not be capable of practising medicine;
 - the physician's patients may be at risk of harm or injury;
 - the physician has missed an appointment without sound reason, or;
 - the physician may not be in compliance with his/her Undertaking.

- Will discuss any concerns, as outlined above, with the physician and will report these immediately to the College;
- Submit regular written quality reports to the College at specified intervals, which contain the following information -
 - The dates that the *Health Monitor* has professionally seen the physician;
 - Major events in the course of the physician’s illness, including any periods of hospitalization, or any period in which s/he was not capable of properly practising medicine;
 - The treatment plan which is prescribed for the physician;
 - The physician’s compliance with the treatment regime;
 - Any other information that might assist the College in assessing the physician’s capacity to practise medicine.
- Be aware of real or perceived biases in relationship with the physician. This is an especially sensitive area, as the *Health Monitor* may be a treating health professional, and will therefore have duties to the patient, which the *Health Monitor* may view as being in conflict with his or her obligations to the College. The *Health Monitor* must nonetheless abide by the terms of his or her undertaking with the College.
- Notify the College if unable to continue in the role.

Core Expectations of the Health Monitored Physician

- Motivated and participates in health monitoring with a clinical therapist approved by the College;
- Respect for the interests of patients and their appropriate care and treatment;
- Open and honest with his or her *Health Monitor* to facilitate the supervision process;
- Respect and collegiality towards the *Health Monitor*;
- Demonstrates meaningful signs of progress towards meeting College expectations;
- Acknowledges that they are responsible for payment of all fees, costs, charges, expenses, etc. arising from the supervision arrangement;
- Gives irrevocable consent to the College to provide any pertinent background information to the *Health Monitor* so that they are sufficiently informed about the physician’s situation in order to carry out their duties effectively;
- Agrees to information sharing amongst *Health Monitor*(s) (if more than one) and the College.

Additional Committee-specific Expectations for the Health Monitored Physician

Executive/ Inquiries, Complaints and Reports/Fitness to Practise Committees – If the *Health Monitor* is unable or unwilling to continue to fulfill the terms of his or her undertaking, then the health monitored physician is obligated to find a replacement to the best of his/her abilities from a similarly qualified person who is acceptable to the College and is not permitted to practice without a *Health Monitor* in place.

Level of Supervision

The level of supervision is typically moderate to high. It is not possible to set out expectations for low, moderate, or high levels of supervision for this type of supervision arrangement. The features of the supervision, i.e. components/tools to be used by the supervisor, availability of the supervisor, and frequency of reports to the College are **uniquely** defined according to the specific circumstances of the physician.

Modifying the Level of Supervision

Supervisors are expected to report immediately to the College any new incapacity concerns; any dangerous or unsafe practices by the physician; or any apparent breaches by the physician of his or her obligations to the College.

The health monitored physician must request a variance to his or her undertaking or order. This request would need to be considered by the appropriate Committee (typically, the Executive, Inquiries, Complaints and Reports or Fitness to Practise Committees) and would require the written support of the *Health Monitor*.

Ending the Supervision Phase

The timeline is always defined by the College, in many cases in conjunction with the PHP. Any decision to altogether cease the supervision arrangement would rest with the source Committee directing the supervision.

How Do We Know Whether Supervision has been Effective?

Depending on the physician's circumstances, the College *may* conduct re-assessment(s) of the physician's health during the course of the physician's health monitoring phase, and/or following completion of health monitoring. The College would also decide whether the goals of the health monitoring arrangement are being met and whether the monitoring should continue. Patient safety is the key consideration in relation to any further steps or decisions made by the College

Appendix 1 –Educational Template (*Sample only*)

<i>EDUCATIONAL NEED</i>	<i>OUTCOMES (GOALS)</i>	<i>PROPOSED EDUCATIONAL METHOD</i>	<i>ASSESSMENT METHOD</i>	<i>EXPECTED COMPLETION DATE</i>
Deficiency in history taking and physical examination skills	Improved ability to take patient history and to perform appropriate physical examination for the given patient presentation	Work with Clinical Preceptor on basic clinical skills with direct observation and feedback on progress	Regular reports to Enhancement team from Clinical Preceptor indicating improvement in basic clinical skills Post-Enhancement reassessment e.g. re-PREP	
Deficiencies in communication skills	Improved communications skills with incorporation of patient-centred method into communications practices	Take CPSO course in Physician-Patient Communication Direct observation by Clinical Preceptor	Successful completion of CPSO course on communications Regular reports to Enhancement team from Clinical Preceptor indicating improvement in communications skills Post-Enhancement reassessment e.g. re-PREP	
Inadequate knowledge base in the clinical management of diabetes	Acquire current knowledge and incorporate current practices into management of diabetes	Research current practices through review of CPG's, taking courses such as those offered by the CFPC, write review of current management and use patient chart reminder system to incorporate current practices into practice. Regular review with Clinical Preceptor regarding issues of management of patients with diabetes	Review of written summary by Clinical Preceptor Regular reports to Enhancement team from Clinical Preceptor indicating improvement in diabetes management Post-Enhancement reassessment e.g. re-PREP	

Appendix 2- Components/Tools of Supervision

The effectiveness of supervision programs will be directly related to the components/tools of supervision selected and their frequency of use. The components/tools outlined below can be used in combination in any type of supervision program. The College will determine which tools, at minimum, should be used by the supervisor.

1. Discussion with Physician (Collegial Peer Review)

- Supervisor shapes the discussion to suit his/her purposes, as well as the concerns identified by the College; can be as unstructured or structured as necessary (i.e. low level supervision based on unsatisfactory performance on PREP may consist of a monthly meeting; high level supervision based on doctor's past inappropriate behaviour towards colleagues may consist of a series of structured questions);
- Supervisor and physician remain in direct contact, maintaining regular communication with each other;
- 'Regular contact' is defined by the situation;

2. Self-Evaluation

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

3. Medical Record Review

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

4. Review of Practice Data

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

5. Direct Observation

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

- Predominantly forms part of moderate and high levels of supervision; may be low level in some cases
6. Interviewing Colleagues/Co-workers
 - A broad spectrum of colleagues and team members (nurses, office staff, social workers, etc.) who work closely with the physician and who will observe, over a period of time, his/her technical skills, patient and colleague communication skills, judgment and practice management issues;
 - The anonymity of interviewees must be secured in any report, if possible and appropriate; however, regardless interviewees should be encouraged to be as candid as possible;
 - A list of structured questions can assist in the interview and help the supervisor in probing certain issues.
 7. Peer/colleague/patient surveys
 - Used in some programs to provide insight into clinical practice (e.g. Registration through Practice Assessment program) or situations to evaluate skills that are not easy to evaluate with other techniques (humanistic and professionalism components) and to receive patient input;
 8. Standardized patients
 - Laypersons trained to portray patients in clinical encounters; they evaluate the communication skills of the candidate using standard protocols;
 - Interaction is observed by a physician assessor in that specialty who evaluates the clinical practice skills, judgement and competence of the physician, e.g. history taking, treatment plans, etc.;
 - Used only in some programs or situations;
 - Useful in settings where direct observation of patient care is not feasible or functionally appropriate, e.g. psychiatry;
 - Can control the type of encounter and direct the evaluation towards certain skills.
 9. Patient Satisfaction Surveys
 - Used in some programs to solicit feedback immediately following the patient's interview with the physician in order gather the patient's impression of the encounter, i.e. physician's communication styles/techniques, physician's attentiveness to patient's needs, and patient's confidence level in the physician's knowledge.
 10. Communication Skills Assessment Tools
 - Used in some programs involving review of patient encounters in order to assesses physician's oral communication skills
 11. Clinical Supervision Log
 - Used typically in Practice Monitoring by the supervisor in order to document weekly/monthly chart reviews and patient care discussions. This log is also useful in subsequent reviews to see if recommendations made were followed through.
 12. Prescription/Narcotic Logs
 - Used typically in Practice Monitoring. Restrictions may be placed on a physician's ability to prescribe narcotics or other drugs. The physician might be required to keep a log of certain drugs prescribed that would then be reviewed and discussed regularly by a *Practice Monitor* or as part of a re-inspection activity.

13. Patient Logs

- Used typically in Practice Monitoring. Some physicians are required to have an approved chaperone present during encounters with all patients or certain patients (females, children, etc.). The chaperone would usually be required to keep a separate log of all patients seen in his/her presence. There may also be a requirement to initial the patient chart. The physician would usually be required to allow the College access to OHIP billing information to allow staff to compare logs.

14. Other Ad Hoc Tools

- Billing records may be available that would help inform the supervision process.