PRA-BC
PRACTICE READY ASSESSMENT
- PHYSICIANS FOR BC

Supervision of PRA-BC Candidates by their Assessors During their Clinical Field Assessment

Introduction

All PRA-BC candidates require a College of Physicians and Surgeons of BC ("the College") Assessment class of registration, as defined in the College bylaws 2-40, 2-41, and 2.43 in order to complete their 12 week Clinical Field Assessment (CFA) experience. Our candidates are also required to hold appropriate CMPA coverage while completing their CFA. Currently, PRA-BC assesses only carefully selected foreign educated physicians (International Medical Graduates or IMGs) who have practiced as family physicians in international jurisdictions. The **purpose** of the PRA-BC program is to determine if a selected PRA-BC candidate is safe to enter independent medical practice as a Most Responsible Physician (MRP) following an intense and comprehensive 12 week summative assessment of competence in a rural community which was preceded by a 3 week orientation and examinations process.

PRA-BC is not an undergraduate or postgraduate training experience which most BC physician supervisors are familiar with and accustomed to undertaking with Canadian medical students and postgraduate Family Practice (FP) residents.

Rather, PRA-BC is a summative assessment of competence utilizing a variety of CFA tools and reporting forms which result in the candidate's assessor providing formative feedback on a daily basis during the 12 week CFA. For example, the Mini-CEX assessments and Field Note forms require the assessor to directly observe the candidate/patient interaction and assess the candidate's competence (or not). Other CFA tools and report forms, apart from directly observing procedural skills, do not require the assessor to directly observe the candidate interacting with a patient.

In summary, PRA-BC candidates:

. are not licensed for independent medical practice as a MRP

. must be supervised at all times by their assessor during their 12 week CFA experience

. cannot write prescriptions, order investigations, or make referrals on their own.

Practically speaking, PRA-BC candidates' College licensure limits are equivalent to a hybrid of a 4th year medical student and a FP resident (except that unlike Canadian FP residents, they cannot write prescriptions). However, PRA-BC candidates are already experienced FPs in their

own international jurisdictions and have been licensed to work there independently as MRPs, often for many years.

So, how does PRA-BC consider all these factors in a pragmatic way to provide guidance to our assessors as to their legal and ethical/professional responsibilities when supervising/assessing our candidates? Whatever PRA-BC recommends to our assessors, it must be congruent with the College's requirements for supervisors and yet be pragmatic to recognize that all PRA-BC assessors are physicians who run very busy medical practices. Additionally, it must reflect CMPA guidance on physicians' duties and responsibilities, including delegation of responsibility.

The Program outlines a concept of "the length of the supervision leash" to assist our assessors with understanding the nature of our summative assessment processes and to enable them to use their own clinical judgment and comfort level as to whether or not they need to sit in on every patient consult with the candidate. How can they be technically supervising PRA-BC candidates at all times and yet not sitting in on every patient/candidate encounter?

A Pragmatic and Practical Approach to Supervising/Assessing a PRA-BC Candidate

During the first 2 to 3 weeks while the assessor is getting to know their candidate's abilities and skill set, it is suggested that the candidate and assessor see patients together for the most part, with the assessor using his/her judgment to allow the candidate to see a few patients initially alone, enabling them to do the intake and assessment, and then presenting the case to the assessor, who would normally do his/her own assessment (with the patient present) before the patient leaves the clinic.

It goes without saying that the assessor must first introduce the candidate to his/her patient and obtain verbal consent from the patient to allow the candidate to consult with them alone. In most cases, the assessor will tell the patient that they will come back to see the patient with the candidate "in a few minutes".

The "length of the supervision leash" can gradually increase as the assessor's discretion, so that by week 6 or 7, the candidate may be seeing many patients alone prior to the assessor then entering the examination room and doing his/her own assessment with the patient present.

It is understood that when the assessor is specifically using the Mini-CEX assessment and completing its forms or using Field Notes to assess one of the candidates' 8 Sentinel Habits, he/she must be present and directly observing the patient/candidate interaction in order to conduct a proper assessment and complete the assessment tools. Normally, this would involve completing at most 1 or 2 Field Notes most days and 2 Mini-CEX forms per week.

It is quite common in a busy practice for the assessor to be seeing a patient alone while the candidate is seeing a second patient alone. Often, in the final 6 weeks of the CFA, if the assessor is tied up with their patient and the candidate has finished their consult, and there is no need for the patient to receive a prescription or go for blood work or imaging studies, or to be referred, the candidate may, if having previously been granted permission by the assessor, discharge the patient from the clinic without the patient having been seen in detail by the assessor. However, in these instances, the assessor must sit down with the candidate at the first available opportunity, but no later than the end of the same clinic session, to review the candidate's clinical findings and recommended treatment/follow-up plan. If the assessor is in agreement with the candidate's overall assessment, he/she should sign off the chart note. If not, the patient should be requested to return to the clinic for follow-up by both the candidate and the assessor.

If any patient requires a prescription, or blood work or imaging studies, or referral, the patient cannot leave the clinic without the assessor "counter-signing" any of these documents. PRA-BC has advised our assessors that the candidate may write out the prescription or complete the test requisition or referral forms but the assessor must counter-sign each document. Normally, this would mean the patient must remain in the clinic until reassessed by the assessor.

In terms of candidates' on-call requirements, the Program is clear to them that they are expected to be on-call when their primary or assigned secondary assessor is on-call for the clinic or for the hospital. If the assessor is working specific ER shifts on-site as the MRP, the candidate will be expected to work the same shifts and be assessed in the same manner as in the assessor's own medical clinic.

If the assessor is on-call for the ER and taking call from home, he/she would normally initially contact the candidate and they would both attend the ER to see the patient(s) together. As the CFA progresses and the assessor is comfortably in "lengthening the supervision leash", the assessor may instruct the candidate to see the patient in the ER and then telephone the assessor at home to discuss the patient just seen by the candidate. It would be left up to the discretion of the assessor to permit the candidate to discharge the patient without the assessor coming into the ER. It would be presumed that any discharge medications for the patient would be provided by the ER staff for 24 to 48 hours to enable the patient to follow-up with their own physician. The assessor would be required to review the patient's presentation and findings the next morning with the candidate and sign off on the physician's ER forms and counter-sign any orders made by the candidate.

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Summary

PRA-BC has provided some general comments about the requirements of our assessors to supervise our candidates and offered some specific examples, with the hope that this information will be of help to our assessors. Ultimately, each assessor must be comfortable with how much "independence" they allow their candidates to see patients on their own. Generally, as an assessor gains confidence in the abilities of their candidate, they will "lengthen the supervision leash" from seeing the patient together with their candidate to giving their candidate more responsibility.

These Program suggestions are just that. Please feel free to contact our Program Director, Dr. Jack Burak, at any time to discuss this topic in more detail or to run specific scenarios past him. The Program suggests that you become familiar with the CMPA document titled "Delegation and Supervision: responsibilities of supervisors and trainees" which is available on the CMPA website.

Dr. A.J. Jack Burak

Clinical Director, PRA-BC

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