COMPANION STATEMENT TO THE SUPERVISION POLICY FOR TRAINEES IN THE CLINICAL TEAM IN UGME AND PGME

PGME-Specific Approach to Supervision, Coaching, Role Modelling, and Assessment

Purpose of this Companion Statement

This document complements, but does not replace, the McGill School of Medicine Supervision Policy for Trainees in the Clinical Team in UGME and PGME (approved 2015, updated April 2023, reviewed August 2024) and the Collège des médecins du Québec (CMQ) Guide du Rôle et responsabilités de l'apprenant et du superviseur (September 2021). It articulates how supervision is operationalized in the postgraduate medical education (PGME) context, where supervision is integrated with structured observation, coaching, role modelling, and a multimodal program of assessment. The principles articulated here apply to all McGill PGME programs, whether accredited under the Royal College of Physicians and Surgeons of Canada (Competence by Design and the CBD Adaptations Plan, 2024) or the College of Family Physicians of Canada (Triple C Competency-Based Curriculum, CanMEDS-FM, and the Continuous Reflective Assessment for Training framework). Where any tension arises between this companion document and the School of Medicine and CMQ Supervision Policies, the latter Policies prevail.

Preamble

This companion document clarifies how clinical supervision is operationalized in the postgraduate medical education (PGME) context. In PGME, supervision is not limited to oversight of patient care; it is a **developmental practice that integrates observation, coaching, role modelling, and programmatic assessment** to support the progressive acquisition of competence required for independent practice.
This document aligns institutional supervision expectations with national competency-based medical education frameworks (Royal College and CFPC) and provides a shared conceptual and operational model for trainees, faculty, and program leadership.

In PGME, clinical supervision extends beyond oversight of patient care. It is a developmental practice that integrates direct and indirect observation, coaching, role modelling, and structured assessment, all directed toward the development of competence for independent practice.
Supervision in PGME must therefore simultaneously achieve two aims:

- **Patient safety and quality of care** — which remains the responsibility of the supervising physician and is shared with a trainee in a graded fashion, to a degree commensurate with their stage of training and competence; and
- **Learner development** through graded responsibility, supported autonomy, longitudinal coaching, and explicit role modelling aligned with the values of the discipline and the profession.

These aims are complementary. The educational environment must be safe for both patient care and effective learning, and supervision practices must be designed to support both at once.

Alignment with Existing Standards and Frameworks

This companion statement aligns the central Supervision Policy with the national, provincial, and institutional frameworks that govern PGME practice at McGill. It is designed to apply equally to programs accredited by the Royal College of Physicians and Surgeons of Canada and to Family Medicine programs accredited by the College of Family Physicians of Canada, recognizing that the two systems share a common philosophy of competency-based medical education while using distinct vocabulary, tools, and assessment architectures.

- Collège des médecins du Québec (CMQ) — Code of Ethics of Physicians (Articles 3 and 42), the CMQ Guide du Rôle et responsabilités de l'apprenant et du superviseur, and Fiches 20 and 21 on telemedicine supervision of trainees;
- Royal College of Physicians and Surgeons of Canada — General Standards of Accreditation for Residency Programs (v3.0, July 2024), the CanMEDS Framework, the Competence by Design (CBD) Coaching Model, the CBD Assessment Technical Guide (June 2025), and the CBD Adaptations Plan (July 2024);
- College of Family Physicians of Canada (CFPC) — the Triple C Competency-Based Curriculum (Comprehensive, Continuous, and Centred in Family Medicine), CanMEDS-FM (2017), the Family Medicine Residency Training Profile, the Continuous Reflective Assessment for Training (CRAFT) framework, the Assessment Objectives for Certification in Family Medicine, and the Standards for Accreditation of Residency Programs in Family Medicine (the "Red Book");
- McGill School of Medicine — Faculty of Medicine and Health Sciences Code of Conduct, the Supervision Policy for Trainees in the Clinical Team, and program-specific PGME Learners' Assessment Guidelines.

Where this companion statement uses Royal College terminology (for example, EPAs, milestones, competence committees), Family Medicine programs should read these as referring to their analogous CFPC structures (for example, competencies and skill dimensions, field notes mapped to domains of care, and the residency program committee acting in its competence committee function). Where it uses CFPC terminology (for example, field notes, domains of care, CanMEDS-FM), Royal College programs should read these as referring to their analogous structures (for example, EPA observation forms, contextual variables, and CanMEDS Roles).

Definitions Specific to PGME Practice

The following definitions extend, but do not replace, those provided in the central Supervision Policy.

Direct Observation

The real-time observation of a trainee performing a clinical task or portion of a task. Examples include observing history-taking, physical examination, procedures, counselling, informed consent discussions, interprofessional communication, handover, resuscitation, family meetings, ward rounds, and case presentations.

Indirect Observation

The use of surrogate data to assess trainee performance without having directly watched the task. This includes review of clinical documentation, oral case presentations, chart review, audio or video recordings (with patient consent), and reports from other healthcare professionals, patients, or families. Indirect observation is a legitimate and valuable source of assessment data, particularly for assessing clinical reasoning.

Coaching

A teaching and assessment practice in which the supervisor uses observed data to guide the trainee through a growth process toward improved performance. Coaching extends beyond traditional feedback by providing specific, actionable suggestions for improvement, not only descriptions of what was observed.

Coaching in the Moment

Coaching that occurs in the clinical environment in proximity to an observed task. It supports learning embedded in daily work and may be structured using the RX-OCR process (Royal College) or analogous approaches commonly used in Family Medicine, such as case-based discussion following direct observation, debriefing of recorded encounters, or post-clinic teaching using field notes (see Section 5).

Coaching Over Time

A longitudinal coaching relationship between a designated coach (often the program director, academic advisor, or assigned faculty coach) and the resident. It draws on data accumulated in the resident's learning portfolio and supports the development of self-regulated learning, individualized learning plans, and progression toward competence.

Educational Alliance
A bidirectional, mutually respectful, and psychologically safe relationship between trainee and supervisor that enables credible feedback and effective coaching. Establishing the educational alliance is a precondition for productive observation and coaching encounters.

Role Modelling
A teaching practice in which trainees learn by observing, reflecting on, and adapting the knowledge, skills, attitudes, behaviours, and professional identity demonstrated by their supervisors and senior colleagues. Role modelling can be implicit or explicit and exerts a powerful influence on professional identity formation and the hidden curriculum.

Programmatic Assessment
A coherent, multimodal system of assessment that combines multiple assessment tools, multiple assessors, and multiple contexts over time to generate evidence about a trainee's development. It includes both assessment for learning (formative coaching) and assessment of learning (summative documentation that informs competence committee decisions).

Units of Workplace-Based Assessment
Each certifying college defines the units used to organize observation and documentation of trainee performance. In Royal College disciplines, these are Entrustable Professional Activities (EPAs) or major tasks (for AFCs) defined by the discipline's national specialty committee, with associated milestones and contextual variables. In Family Medicine, these are the competencies and skill dimensions of the Assessment Objectives for Certification in Family Medicine, typically documented through field notes and mapped to the domains of care described in the Family Medicine Residency Training Profile. In both systems, demonstration of competence in the units defined by the certifying college is required for certification, and the wording of these units cannot be modified locally.

Field Note
A brief, focused, written record of an observation of a resident's clinical performance, used predominantly in Family Medicine. Field notes capture what was observed, what was done well, and what could be improved, and are mapped to CanMEDS-FM Roles, the relevant domain of care, and the relevant skill dimension. Field notes are the primary source of documented formative feedback in CFPC programs and, in aggregate over time, support summative judgments about competence.

CanMEDS and CanMEDS-FM Frameworks
CanMEDS (Royal College, 2015) and CanMEDS-FM (CFPC, 2017) describe the abilities physicians require to meet the health care needs of the people they serve. Both frameworks identify a central expert role surrounded by intrinsic Roles (Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional). Supervision, coaching, role modelling, and assessment in McGill PGME programs are oriented to the development of all CanMEDS or CanMEDS-FM Roles, not the medical expert role alone.

Domains of Care (Family Medicine)
Areas of clinical practice within which Family Medicine residents are expected to develop competence, including (but not limited to) care of children and adolescents, care of adults, care of the elderly, maternity and newborn care, behavioural medicine and mental health, palliative and end-of-life care, and care of underserved populations. Programs of assessment in Family Medicine are designed to ensure that observation and feedback span the full range of domains.

In-Training Assessment Reports (ITARs / ITERs)
Periodic, summative records of a resident's performance over a defined period, completed by supervisors based on direct and indirect observation, narrative feedback, and review of accumulated assessment data. Both Royal College and CFPC programs use these documents (typically called ITARs in Family Medicine and ITERs in Royal College disciplines) as one component of a multimodal program of assessment. They complement, but do not replace, observation-based formative assessment.

Guiding Principles

PGME supervision in the McGill setting is guided by the following principles:

- **Patient safety is paramount** — overall responsibility for patient care is shared between the supervising physician and trainee in a graded fashion, to a degree commensurate with their stage of training and competence.
- **Psychological safety is essential** — supervisors create learning environments free of bias and discrimination in which trainees can ask questions, acknowledge limitations, seek help, and receive feedback without fear of inappropriate consequences.
- **Supervision is graduated** — the level and nature of supervision are calibrated to the trainee's stage of training, demonstrated competence, the clinical context, and patient-specific factors.
- **Observation is foundational** — meaningful coaching and credible assessment depend on observation of the trainee's actual work, whether direct or indirect.
- **Coaching is integral to supervision** — supervisors are expected to coach, not only to oversee. Coaching transforms observation into learning by generating actionable steps for improvement.
- **A growth mindset underpins effective coaching** — both supervisors and trainees approach learning as a developmental process, recognizing that competence is built through deliberate practice, feedback, and reflection.
- **Role modelling is always occurring** — supervisors are role models for residents, and senior residents are role models for junior trainees and medical students. Role modelling should be made conscious, explicit, and reflective wherever possible.
- **Assessment is multimodal** — no single tool or observation can adequately capture competence. Programs use a coherent combination of workplace-based observations (EPA observation forms in Royal College disciplines, field notes in Family Medicine), ITARs/ITERs, multi-source feedback, OSCEs and SOOs, written assessments, narrative feedback, and other tools.
- **Responsibility for assessment is shared** — both faculty and trainees have responsibility for triggering, completing, and documenting observations in a timely manner.
- **Inclusive practice is intentional** — supervisors recognize that role modelling and the hidden curriculum can perpetuate harm if left unexamined; reflection on these dynamics is encouraged at the program and faculty level.
- Feedback is bidirectional — effective learning environments support constructive feedback from teacher to learner and from learner to teacher, fostering reflection, growth, and continuous improvement for both.

Core Functions of PGME Supervision

PGME supervision integrates four interdependent functions: clinical oversight, observation, coaching, and contribution to programmatic assessment. These are not separate activities but overlapping facets of the same supervisory practice.

Clinical Oversight

Consistent with the central Supervision Policy, the supervising physician maintains responsibility for patient care, delegates patient assignments commensurate with the trainee's ability and stage of training, reviews findings and management plans, countersigns trainee notes, and remains readily available for consultation. Telemedicine supervision follows CMQ Fiches 20 and 21.

Observation

Observation is the foundation of PGME supervision. Both direct and indirect observation generate valuable data about trainee performance, and both contribute to coaching and assessment. Direct observation is particularly valuable for assessing communication, procedural skills, and behaviours that cannot be inferred from documentation. Indirect observation, including review of charts, oral case presentations, and feedback from other

team members, is particularly valuable for assessing clinical reasoning, judgment, and longitudinal patterns of practice.

Observations should:

- Occur frequently across the duration of training, not only at the end of rotations;
- Capture a variety of clinical contexts, presentations, and patient populations;
- Involve multiple supervisors over time to provide a balanced perspective;
- Be free of bias and discrimination
- Generate data that can be used both for in-the-moment coaching and for longitudinal tracking of progression.

Coaching

Coaching transforms an observation into a learning opportunity. It is structured around the educational alliance and oriented toward actionable improvement.

Coaching in the Moment: structured approaches

Programs are encouraged to provide faculty and residents with a shared, explicit framework for coaching encounters. The Royal College RX-OCR process is one widely used framework and is recommended for CBD programs. Family Medicine programs and others may use analogous structured approaches that share the same underlying logic of rapport, expectation-setting, observation, coaching conversation, and documentation. Whatever framework is adopted, the underlying principles are common across certifying colleges.

The five steps of the RX-OCR process are:

- R — Rapport: Establish an educational alliance with the trainee.
- X — eXpectations: Set explicit expectations for the encounter, including learning goals, roles, and a safe learning environment.
- O — Observe: Observe the trainee directly or indirectly.
- C — Coach: Engage in a coaching conversation focused on actionable improvement.
- R — Record: Record a summary of the encounter where appropriate, contributing to the program of assessment.

Coaching Over Time

Programs should ensure that each resident has access to longitudinal coaching, typically through an academic advisor, faculty coach, or program director. Coaching over time uses data accumulated in the learning portfolio to support reflection, co-construction of learning goals, and the development of self-regulated learning skills. While the Royal College accreditation standards do not currently mandate longitudinal coaching beyond the existing six-month resident review, programs are strongly encouraged to embed longitudinal coaching as a core element of the trainee experience.

Contribution to Programmatic Assessment

Observations and coaching encounters generate data that, when documented, contribute to the resident's program of assessment. This data:

- Supports timely formative feedback to the resident;
- Builds, over time and across observers, a representation of the trainee's developmental trajectory;
- Informs the decisions of the residency program committee, competence committee, or equivalent body, regarding entrustment, progression, promotion, individualized learning plans, and readiness for certification.

Programs of assessment must be multimodal. No single tool can adequately capture the breadth of competence required for independent practice. A coherent program of assessment integrates a variety of tools, matched to the competencies being assessed and the educational experiences in which they are demonstrated. Tools commonly used across McGill PGME programs include:

- Workplace-based observation tools — EPA observation forms (Royal College disciplines) and field notes (Family Medicine), used to document direct and indirect observation of clinical performance;

- Periodic summary assessments — In-Training Assessment Reports (ITARs) in Family Medicine and In-Training Evaluation Reports (ITERs) in Royal College disciplines, capturing longitudinal performance over a rotation, block, or training period;
- Narrative feedback — open-text comments that describe observed performance and provide actionable suggestions for improvement;
- Multi-source feedback — structured input from peers, allied health professionals, patients, and other team members, particularly valuable for assessing the intrinsic CanMEDS / CanMEDS-FM Roles;
- Structured examinations — Objective Structured Clinical Examinations (OSCEs), Simulated Office Orals (SOOs, used in Family Medicine), and written assessments;
- Progress reports and longitudinal reviews — typically every six months, summarizing progress and informing learning plans.

Consistent with the Royal College CBD Assessment Technical Guide and CBD Adaptations Plan, and with the CFPC Continuous Reflective Assessment for Training (CRAFT) framework, programs should not rely exclusively on any single tool. Royal College programs should not over-rely on EPA observations alone, and Family Medicine programs should not over-rely on field notes alone. In both cases, the goal is a coherent combination of tools, multiple assessors, and multiple contexts that together support credible decisions about progression and certification.

Programs should also create deliberate opportunities for low-stakes, undocumented feedback. Not every coaching conversation needs to be recorded; reserving space for informal coaching protects the educational alliance and reduces the perception of constant evaluation.

Role Modelling in PGME

Role modelling is one of the most powerful mechanisms by which residents learn and develop their professional identity. It operates continuously, often implicitly, and shapes both the formal and the hidden curriculum of the training environment.

All clinical supervisors and senior residents are role models. Effective role modelling has two phases: the exposure phase, in which the trainee observes the model's attitudes, values, and behaviours; and the evolution phase, in which the trainee reflects on, adapts, and decides whether to internalize what was observed. Programs and supervisors are encouraged to:

- Be aware that role modelling is continuous and exerts influence regardless of intent;
- Make role modelling explicit by helping trainees focus on what is being demonstrated and inviting reflection on it;
- Engage trainees in conversation about observed clinical and professional behaviours, including challenging or imperfect ones;
- Reflect on how the hidden curriculum and dominant cultural norms may shape what is being modelled, and create space for residents to identify and discuss role modelling that may perpetuate harm;
- Support residents to develop the skills to role model effectively for medical students and junior trainees;
- Recognize the value of diverse role models and, where possible, help residents connect with mentors and role models from their own communities.

Graduated Responsibility and Entrustment

Supervision is calibrated to the trainee's demonstrated competence. Decisions about how much to delegate, observe directly, or assist are informed by:

- Trainee factors — stage of training, demonstrated competence in the relevant tasks, accumulated assessment data, and self-identified learning needs;
- Patient factors — complexity, acuity, vulnerability, and the patient's preferences regarding trainee involvement;

- **Context factors** — clinical setting, time of day, available resources, and the supervisor's familiarity with the trainee.

Where a senior trainee has been delegated supervisory responsibilities for a junior trainee, the senior trainee assumes the obligations described in the central Supervision Policy. The delegating supervisor retains overall responsibility for patient care and for ensuring the senior trainee has the teaching and supervisory skills required.

Shared Responsibilities for Observation and Documentation

Consistent with the Royal College Standards of Accreditation and the CBD Adaptations Plan, residents and faculty have shared responsibility for ensuring that observation and assessment activities take place and are appropriately documented.

Faculty Responsibilities

- Trigger and complete observations in a timely manner, including narrative feedback;
- Provide actionable coaching, not only descriptive feedback;
- Ensure that documented observations are completed within timelines set by the program;
- Mitigate bias and discrimination in observations and documentations;
- Notify the Program Director or Site Director of concerns about a trainee's progression, including early identification of a resident-in-difficulty.

Trainee Responsibilities

- Identify learning goals and seek out observation opportunities;
- Trigger assessments where appropriate, including completion of resident-driven observation forms;
- Engage actively in coaching conversations and reflect on actionable feedback;
- Notify supervisors of limitations and seek assistance when appropriate;
- Notify the Program Director or Site Director of concerns about the level or quality of supervision.

Program Responsibilities

- Map all required competencies, EPAs (Royal College) or skill dimensions and domains of care (Family Medicine), and other training requirements to training experiences and assessment strategies;
- Implement and clearly communicate a multimodal program of assessment that includes EPA-based and non-EPA-based data;
- Provide faculty development on observation, coaching, role modelling, and the use of the program of assessment;
- Provide resident orientation to the coaching framework used by the program (e.g., RX-OCR for Royal College disciplines, equivalent structured approaches for Family Medicine), the program of assessment, and mechanisms for raising concerns;
- Support competence committees (Royal College) and residency program committees (Family Medicine) in making evidence-informed decisions on progression, promotion, and individualized learning plans;
- Identify and respond to systemic barriers to observation and coaching, including unmanageable assessment burden.

Trainees Requiring Additional Support

Programs are expected to identify trainees who may benefit from additional support as early as possible and to develop individualized / modified learning plans in collaboration with the trainee. Where a supervisor identifies concerns about a trainee's performance, professionalism, or wellness, the supervisor should:

- Provide direct, specific, and timely feedback to the trainee through coaching;
- Document the observation through the program's usual assessment tools;
- Notify the Program Director or Site Director of the concern, in line with program-specific procedures;
- Continue to provide a safe and supportive learning environment while the concern is addressed.

Residents and faculty are reminded of the existing mechanism to raise concerns about the level or quality of supervision, and to escalate to the Program Director, Site Director, or PGME Office as appropriate.

Managing the Burden of Assessment

McGill PGME programs are encouraged to take active steps to ensure the assessment system supports learning rather than overwhelming residents and faculty. This priority is reflected in the Royal College CBD Adaptations Plan (July 2024) and is consistent with the CFPC Continuous Reflective Assessment for Training (CRAFT) framework, which similarly cautions against over-reliance on any single assessment tool. Common challenges across both certifying systems include unmanageable documentation expectations, performative observation, fragmented feedback, and erosion of trust between residents and faculty when assessment crowds out coaching.

Programs are encouraged to:

- Rebalance the program of assessment — Royal College disciplines should avoid sole or near-sole reliance on EPA observations, and Family Medicine programs should avoid sole or near-sole reliance on field notes. In both cases, a coherent combination of tools (ITARs/ITERs, narrative feedback, multi-source feedback, OSCEs, SOOs, structured examinations, and others) provides a more robust and less burdensome basis for decision-making;
- Exercise local discretion within national standards — with PGME Office oversight, programs and decision-making bodies (competence committees in Royal College disciplines; residency program committees in Family Medicine) may determine the number of observations required for entrustment or competence in each unit of assessment, recognizing that national numbers are guidelines, not requirements;
- Protect space for undocumented coaching — not every observation needs to be recorded; deliberate space for low-stakes feedback supports the educational alliance and a growth mindset, and is endorsed by both the Royal College and CFPC frameworks;
- Invest in faculty development — to support faculty in delivering high-quality coaching free from bias and discrimination, completing assessments in a timely manner, and engaging meaningfully with the program of assessment.

Implications for Faculty Development

Effective implementation of this companion statement requires ongoing faculty development. Programs, in partnership with the PGME Office and the Institute for Health Sciences Education, should ensure that faculty have opportunities to develop and refine competencies in:

- Direct and indirect observation of trainees;
- Coaching, including the RX-OCR process, the educational alliance, and the growth mindset;
- Role modelling, including conscious, explicit, and reflective practice and awareness of the hidden curriculum;
- Use of the program of assessment, including timely completion of EPA observation forms (Royal College) or field notes (Family Medicine), narrative feedback, ITARs/ITERs, and longitudinal progress reports;
- Identification and support of trainees in difficulty;
- Mitigation of bias and discrimination;
- Inclusive supervisory practice.

Senior residents who have been delegated supervisory responsibilities should also have access to teaching and coaching skill development as part of their training.

Relationship to the Central Supervision Policy and to Program-Specific Policies

This companion statement does not replace the McGill School of Medicine Supervision Policy for Trainees in the Clinical Team in UGME and PGME or the Collège des médecins du Québec (CMQ) Guide du Rôle et responsabilités de l'apprenant et du superviseur (September 2021). It supplements those policies by articulating the PGME-specific operationalization of supervision in the era of CBD and the CBD Adaptations Plan. Where any conflict arises, the central Supervision Policy and other Central PGME policies prevail.

Programs are encouraged to incorporate the elements of this companion statement into their program-specific supervision policies and assessment processes and to review program-specific guidance against this statement on a regular basis.

This companion statement should be read in conjunction with:

- The McGill PGME Supervision Policy for Trainees in the Clinical Team in UGME and PGME;
- Program-specific supervision policies and PGME Learners' Assessment Guidelines;
- The Royal College Competence by Design Coaching Model, the CBD Assessment Technical Guide, and the CBD Adaptations Plan (July 2024);
- The CFPC Triple C Competency-Based Curriculum, the Family Medicine Residency Training Profile, the CanMEDS-FM (2017) framework, the Continuous Reflective Assessment for Training (CRAFT) framework, and the Standards for Accreditation of Residency Programs in Family Medicine (the "Red Book");
- The CanMEDS Framework (Royal College, 2015);
- The CMQ Code of Ethics of Physicians and the CMQ Guide du Rôle et responsabilités de l'apprenant et du superviseur (September 2021).

History: Since onsite accreditation visit 2019

Reviewed and approved at FPGEC: 2026-05-27
Next scheduled review: 2029

Central PGME policies take precedence over all program-specific policies and over this companion statement where any conflict arises.