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COMMENTARY AND OPINIONS

Competency over co-location: redefining clinical supervision in distributed family medicine education

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La compétence plutôt que la colocalisation : redéfinir la supervision clinique dans la formation en médecine de famille à distance

Does effective clinical supervision require a supervising physician to be physically present? Family medicine residents increasingly train and provide care in rural and remote communities where immediate, in-person supervision may be neither practical nor expected. Traditional models of postgraduate medical education, however, have largely equated effective supervision with direct oversight and physical proximity.[1] How we train residents has changed faster than how we define supervision.

These models have understandably emphasized direct observation, immediate availability, and point-of-care teaching as hallmarks of effective supervision.[1] While these remain valuable educational practices, they are no longer adequate definitions of supervision. Competency-based medical education shifts the central question from whether supervision can occur at a distance to how supervision should be calibrated to support learner development and patient safety. Entrustment-based assessment explicitly links learner competence to the level or type of supervision required for safe, high-quality care.[2] The question is therefore no longer whether remote supervision can achieve the same educational standards as traditional models, but whether traditional definitions of supervision remain appropriate for distributed family medicine education.

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We argue that distributed family medicine education requires a paradigm shift in how clinical supervision is understood. Supervision should be defined not by geography, but by educational relationships, progressive entrustment, accessible clinical support, and accountability for patient care. In other words, effective supervision should prioritize competency over co-location.

Resident-led clinics in Northern Saskatchewan illustrate this shift. Family medicine residents provide longitudinal care in remote First Nations communities located more than an hour from their su-ervising physician, supported through telephone consultation, case review, and longitudinal faculty relationships. In our qualitative evaluation, residents described these clinics as among the most formative experiences of their training, fostering clinical confidence, independence, and cultural humility while also identifying challenges related to delayed feedback and occasional professional isolation.[3] These findings suggest that the defining challenge of remote supervision is not geographic separation itself, but ensuring that learner autonomy de-elops within an intentionally designed supervisory system.

Historically, models of clinical supervision have emphasized direct observation and immediate supervisor availability as central mechanisms for ensuring learner development and patient safety.[1] Contemporary entrustment models, however, conceptualize supervision as something that should be calibrated to the level of responsibility a learner can safely assume.[2] If competence rather than proximity becomes the organizing principle of supervision, geographic distance becomes one contextual factor among many rather than its defining feature. Competence itself is contextual. Residents entering new clinical environments must recognize contextual differences and adapt their practice accordingly.[4] Residents should therefore neither receive greater autonomy simply because they are geographically distant, nor experience diminished educational opportunities because their supervisor is not physically present.

Recognizing remote supervision as a distinct educational model has important implications for postgraduate family medicine training. Research involving remotely supervised family medicine training in Canada and Australia has highlighted the importance of ongoing supportive supervisory relationships, continuity, and increasing responsibility, while questioning co-location as the organizing principle for residency education.[5] Rather than attempting to recreate traditional bedside supervision at a distance, distributed family medicine education should intentionally design supervisory systems around these principles. We propose that such systems incorporate progressive entrustment, longitudinal faculty-resident relationships, faculty development specific to remote supervision, meaningful partnerships with the communities in which training occurs, and evaluation based on educational quality, patient safety, and community outcomes rather than physical proximity alone.

Rural and remote family medicine training exposes residents to clinical and community contexts that may differ substantially from those in which they previously trained. Developing competence across these settings requires residents not simply to transfer existing skills, but to recognize contextual differences and adapt their practice accordingly.[4] Educational systems should therefore recognize the edu-ational value of these environments and develop supervisory models that support increasing responsibility while maintaining equivalent educational standards.

Distributed family medicine education no longer requires us to ask whether remote supervision is acceptable. Instead, it requires us to ask whether our current definition of supervision remains fit for purpose. The future of clinical supervision in distributed family medicine depends not on recreating historical models across geographic distance, but on embracing competency over co-location as the defining principle of educational oversight. By intentionally designing, supporting, and evaluating remote supervision on its own terms, family medicine education can strengthen learner development, patient safety, and socially accountable training for the communities it serves.

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