

National University Teaching Awards

2026

THE SOUTH AFRICAN SWAT COLLABORATIVE (SA-SWAT-C)

Beginner Teachers	
Experienced Teachers	
Teachers & Learning Specialists	
Teaching & Learning Collaborative teams	X

Applicant Information

Team Leader & Contact Person

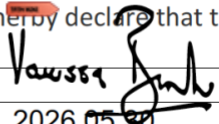
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Signature:	

Team Members (See details in Evidence document)

- Dr Madeleine Muller
- Prof Richard Cooke
- Prof Hanneke Brits
- Prof Bob Mash
- Prof Mergan Naidoo
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Application for NUTA AWARDS: SA-SWAT-C

The South African Supervisor Workplace Assessment and Teaching (SWAT) Collaborative (SA-SWAT-C) was established in response to a national need for faculty development in workplace-based assessment (WBA) as South Africa transitioned towards competency-based postgraduate medical education. The team brought together experienced clinician-educators, faculty developers, and health professions education leaders from multiple universities and disciplines, creating a unique collaborative network with expertise in assessment, curriculum development, clinical supervision, faculty development, online learning, and educational leadership.

Why does South Africa need a SWAT Training

The development of the Supervisor Workplace Assessment and Teaching (SWAT) programme was driven by the national implementation of workplace-based assessment (WBA) within postgraduate specialist training in South Africa. In 2019, a joint national WBA Steering Committee was established by the Colleges of Medicine of South Africa (CMSA), which oversees specialist exit examinations, and the South African Committee of Medical Deans (SACOMD), which represents the universities responsible for registrar training. The committee was tasked with guiding the introduction of competency-based medical education (CBME), with workplace-based assessment as a central component of postgraduate specialist training. Following a series of pilot initiatives, national implementation commenced in 2025 (Nel et al., 2022).

Workplace-based assessment represents a significant shift in postgraduate medical education. Unlike traditional assessment approaches that focus primarily on knowledge and examination performance, WBA evaluates trainees' performance in authentic clinical contexts and provides immediate, meaningful feedback (Burch, 2019; Norcini & Burch, 2007). At its core, WBA is a teaching activity. Its educational value lies not in assessment of learning, but in assessment for learning, where observation and feedback are used to facilitate ongoing professional growth (Burch, 2019; Frank et al., 2010).

High-quality feedback has been shown to improve clinical performance, enhance learning, and ultimately contribute to better patient outcomes (Watling et al., 2012). Registrars consistently identify feedback as one of the most valuable aspects of workplace-based assessment (Massie & Ali, 2015). However, the effectiveness of WBA depends heavily on the skills and attitudes of clinical supervisors who observe performance, facilitate reflection, and provide developmental feedback.

Registrars spend four to five years training within complex clinical learning environments. During this period, much of their learning is shaped by interactions with clinical supervisors, whose primary responsibilities are often focused on patient care and service delivery. Although these supervisors play a pivotal role in registrar development, relatively few have received formal preparation in educational supervision, mentoring, assessment, or feedback. Concerns regarding the quality and consistency of supervision and feedback have therefore been widely reported (Bindal et al., 2011; Holmboe et al., 2011).

The successful implementation of workplace-based assessment requires more than the introduction of new assessment tools; it requires a fundamental shift in educational practice.

Clinical supervisors must adopt new approaches to observation, coaching, feedback, and entrustment decision-making. Such change requires effective faculty development and deliberate change management. Velthuis et al. (2018) identify three common challenges in educational change initiatives: engaging diverse stakeholders, managing resistance to change, and facilitating transformation among highly autonomous professionals. These challenges are particularly relevant within the South African clinical environment, where supervisors face substantial service pressures and varying levels of motivation and experience in teaching.

During 2023 and 2024, the National WBA Committee conducted focus groups across South Africa's medical schools to explore the feasibility of implementing workplace-based assessment. A consistent finding was the urgent need for faculty development that would equip clinical supervisors with the knowledge, skills, and confidence required to conduct WBAs and provide effective feedback (Daitz et al., 2026).

To address this need, the CMSA partnered with the South African Academy of Family Physicians (SAAFP), which has extensive experience in faculty development through its established five-day Training of Clinical Trainers (TCT) programme (Brits, 2024; Mash et al., 2018). A multidisciplinary team of educators was tasked with conceptualising and developing a training programme that would be educationally rigorous, nationally scalable, and feasible within the realities of busy clinical workplaces. Key design considerations included time constraints, geographical distribution of supervisors, variable educational experience, and the need to engage clinicians from multiple disciplines and institutions.

The introduction of workplace-based assessment presents a unique opportunity not only to strengthen assessment practices, but also to transform the culture of clinical supervision within postgraduate medical education. By equipping supervisors with practical skills in observation, feedback, mentoring, and entrustment, SWAT aims to enhance the quality of registrar training, foster supportive learning environments, and contribute to the development of reflective, competent, and compassionate specialists. The programme has therefore been intentionally designed to be accessible, flexible, and relevant to the realities of contemporary clinical practice, enabling widespread participation while supporting meaningful educational change across the South African health professions education landscape.

Introduction to the SA-SWAT-C

The initiative originated through the leadership of Prof Vanessa Burch, Executive Director of Education and Assessment at the Colleges of Medicine of South Africa (CMSA), and Mr Brian Gardner, Assessment Specialist at the CMSA. Recognising the need for a scalable and sustainable faculty development programme, they convened a team to conceptualise and develop training to prepare clinical supervisors for their evolving educational roles in workplace-based assessment.

The initial development team comprised Prof Hanneke Brits (University of the Free State), Adjunct Professor Richard Cooke (University of the Witwatersrand), and Prof Bob Mash (Stellenbosch University), all experienced facilitators within the South African Academy of Family Physicians' nationally recognised Training of Clinical Trainers (TCT) programme. Their extensive expertise in faculty development provided a strong educational foundation for the SWAT initiative.

Dr Madeleine Muller (Walter Sisulu University) joined the team because of her experience in curriculum development, educational innovation, and the design and implementation of large-scale online learning programmes through the CMSA Diploma in HIV Management. Her expertise contributed significantly to the development of the blended-learning architecture of SWAT, including the asynchronous online curriculum hosted on the Learn@CMSA platform.

Together, the team developed the initial vision and structure of the SWAT programme. The resulting curriculum combined twelve hours of highly interactive face-to-face learning with twelve hours of asynchronous online learning, creating a flexible faculty development model capable of meeting the needs of busy clinical supervisors. From the outset, the programme was designed not only to provide knowledge and skills, but also to promote reflection, professional identity formation, and transformation in educational practice.

As the programme evolved, additional expertise was incorporated to strengthen its multidisciplinary and national reach. Prof Mergan Naidoo, Prof Tashneem Harris, and Prof Veena Singaram joined the SA-SWAT-C to assist with adapting the programme for online delivery and to ensure its relevance across diverse clinical disciplines and institutional contexts. Their contributions expanded the educational perspectives represented within the programme and enriched its applicability across the South African postgraduate training environment.

A defining strength of the SWAT initiative has been its collaborative nature. Rather than being owned by a single institution or discipline, the programme was developed through a national partnership that drew on the collective expertise of clinician-educators across South Africa. The team intentionally sought to create a common educational language and shared framework for clinical supervision that could be implemented across all medical specialties while remaining sensitive to local contexts and disciplinary differences.

The SA-SWAT-C also recognised that sustainable educational change requires capacity building beyond the core development group. Consequently, a national network of SWAT trainers has been established, comprising educators from multiple universities and clinical disciplines who have been trained to facilitate SWAT within their own institutions. This distributed model has enabled widespread implementation while maintaining consistency in programme philosophy, curriculum design, and educational standards.

For the purposes of this NUTA application, the team represented includes those individuals who were primarily responsible for the conceptualisation, development, implementation, evaluation, and ongoing stewardship of the SWAT programme. Their collective work has contributed to establishing one of the first coordinated national faculty development initiatives designed specifically to support workplace-based assessment and competency-based specialist training in South Africa.

Phase 1: The SWAT Face-to-Face 2-day Training

The introduction of workplace-based assessment (WBA) required more than the dissemination of new assessment tools. It required a fundamental shift in the educational practices of clinical supervisors, many of whom had limited formal training in supervision, assessment, or feedback. The SWAT programme was therefore intentionally designed as a faculty development intervention aimed at supporting both individual behaviour change and broader educational culture change within postgraduate specialist training.

Drawing on principles of adult learning, experiential learning, transformative learning, and change management (Cranton, 2016; Joseph Galli, 2018; Kolb, 2015; Taylor & Hamdy, 2013), the SA-SWAT-C sought to create a learning experience that would be practical, reflective, and directly applicable to the clinical workplace. The programme was designed around authentic workplace challenges and emphasised active

participation, discussion, reflection, and skills practice rather than passive knowledge transmission.

A major design consideration was the reality of the South African clinical environment. Clinical supervisors work within busy service-delivery settings, often under significant resource and time constraints. Faculty development therefore needed to be relevant, efficient, and immediately applicable. The team deliberately avoided lengthy theoretical lectures and instead structured the programme around practical activities that allowed participants to experience, discuss, and reflect on the principles of workplace-based assessment.

The original SWAT programme was delivered as a two-day face-to-face workshop consisting of four integrated modules:

1. Workplace-Based Assessment (WBA) 101
2. Know Yourself, Your Registrar, and Your Environment
3. Effective Feedback
4. Entrustment and Clinical Competency Committees

Together, these modules addressed both the technical and relational dimensions of workplace-based assessment. Participants were introduced to the principles of competency-based education, observation, feedback, and entrustment while simultaneously developing greater awareness of the interpersonal, emotional, and environmental factors that influence learning and supervision.

A distinctive feature of the curriculum was the deliberate integration of emotional competence, reflective practice, and workplace culture alongside traditional assessment concepts. The team recognised that effective workplace-based assessment depends not only on technical assessment skills but also on the quality of relationships between supervisors and trainees, the psychological safety of learning environments, and the ability of supervisors to engage in constructive educational conversations. This holistic approach distinguished SWAT from many traditional faculty development programmes that focus primarily on assessment tools and procedures.

The programme was initially piloted with clinical supervisors from multiple disciplines and institutions. Evaluation data, participant feedback, facilitator reflections, and informal discussions were used continuously to refine the curriculum. This iterative approach allowed the programme to evolve rapidly in response to participant needs and implementation challenges. Exercises were modified, new activities were introduced, language was adapted, and educational resources were expanded as the team gained experience facilitating the programme. The willingness of facilitators to critically evaluate their own educational practice mirrored the reflective approach that the programme sought to cultivate among participants.

The face-to-face programme also created opportunities for interdisciplinary engagement. Clinical supervisors from diverse specialties were brought together to discuss common educational challenges, compare approaches, and develop a shared understanding of workplace-based assessment. Participants frequently reported that this cross-disciplinary interaction was one of the most valuable aspects of the programme, enabling them to appreciate both the universal principles of supervision and the unique contextual factors influencing different specialties.

Evaluation findings consistently demonstrated high levels of participant engagement and perceived relevance. Supervisors valued the practical nature of the workshops, the opportunity to discuss real-world challenges, and the emphasis on skills that could be applied immediately in clinical practice. Importantly, participants reported increased confidence in conducting workplace-based assessments, providing feedback, and supporting registrar learning.

A first master SWAT training was rolled out in February 2025. The SA-SWAT-C shared responsibility for creating the content for the 12 hours of interactive classroom time that would take place over a 2-day period. As a collective, the SA-SWAT-C brainstormed and identified innovative activities for each of the 4 modules.

The SWAT training for master trainers was piloted in February 2025. Key clinical supervisors (mostly HODs) from 9 medical schools were invited to participate. HB, MM, RC and BM facilitated the sessions. It was scheduled as a 2-day training and was accredited for 12 CPD points (10 general and 2 ethics). Through extensive interaction and input from the trainees, the content and the exercises were refined and improved.

The asynchronous component was developed and loaded on the Learn@CMSA platform and provided participants with access to readings, video lectures, self-reflection activities, assessment resources, and supplementary learning materials. Particular attention was paid to creating resources that were concise, engaging, and directly applicable to clinical practice (See Addendum F). This approach enabled participants to engage with foundational concepts at their own pace and revisit content as needed. MM, in consultation with RC, HB, and BM, compiled the materials that completed each module on the asynchronous learning platform. Each of the 4 asynchronous online modules was CPD-accredited for 3 CPD points (3 hours of content).

The online platform included the following:

- 3 key articles to read
- Videos that elucidated key concepts
- Useful tools/ aids
- A quiz.

The success of the face-to-face programme provided proof of concept for the SWAT curriculum and established a strong foundation for subsequent national expansion. It demonstrated that a faculty development programme could effectively prepare clinical supervisors for workplace-based assessment while simultaneously fostering reflection, professional growth, and educational leadership.

Phase 2: The CMSA SWAT Online Webinar Training

Although the initial face-to-face SWAT programme was well received, it quickly became apparent that this delivery model alone would be insufficient to meet the growing national demand for faculty development in workplace-based assessment. South Africa's specialist training programmes are geographically dispersed, and many clinical supervisors face substantial service-delivery commitments that limit their ability to attend multi-day face-to-face workshops. If workplace-based assessment was to be implemented successfully at a national level, a more accessible and scalable training strategy was required.

The SA-SWAT-C therefore undertook the ambitious task of redesigning the programme for online delivery. This process involved far more than transferring existing workshop content into a virtual environment. The team recognised that effective online learning requires deliberate educational design, active learner engagement, and thoughtful adaptation of teaching strategies to exploit the opportunities afforded by digital platforms.

To improve access to the training for clinical supervisors, Phase 2 introduced a webinar-based version of the face-to-face training. MM, who had been organising SWAT training at WSU and NMU, piloted a webinar-based version of the face-to-face training for Eastern Cape participants. Overall acceptability was high among all participants, and it was decided to create a national webinar-based SWAT training program managed through the CMSA online platform.

The challenge was to preserve the highly interactive, reflective, and experiential nature of the original programme. Many of the most valued aspects of SWAT—including small-group discussions, role-play activities, simulation exercises, and reflective practice—were traditionally regarded as difficult to deliver effectively in virtual environments. The team therefore approached the redesign process as an opportunity for educational innovation rather than merely a logistical solution.

Using a WhatsApp group that has been created for SWAT trainers in South Africa, clinical supervisors that had been training on the face-to-face training were asked for input, and several online meetings were organised to review each of the modules and adapt the modules for an online platform. The interactive webinar component focused on application, discussion, reflection, and skills development. Rather than using webinar time for content transmission, facilitators concentrated on interactive learning activities that enabled participants to engage with concepts introduced during the asynchronous phase.

This flipped-classroom approach aligned with contemporary best practice in health professions education and enabled the programme to maximise participant engagement while respecting the time constraints of clinical supervisors.

The CMSA identified 4 to 7pm as the best timeslot for a 3-hour webinar. The 12-hour face-to-face training was therefore divided into 4 webinars, each covering one of the 3-hour modules. The CMSA provided administrative support and marketing (Addendum A). The trainings are marketed for any clinical supervisor, regardless of university or discipline, who mentors or supervises registrars. Trainees also register on the Learn@CMSA site for the additional 12 hours of asynchronous content. This adaptation made it possible to create a flexible route to obtaining a full SWAT certificate – the 4 interactive modules could be completed as suited to the trainee. If a clinical supervisor had only attended 2 modules of the face-to-face training, they could catch up on the 2 missing modules as an interactive webinar. The CMSA online webinar SWAT will take place 4 times in 2026, allowing missed webinars to be made up in

later sessions. The Asynchronous modules cannot also be completed as 4 different modules, at any time during 2026. This flexibility hugely increases access for trainees who wish to complete the training.

SWAT Training DATA February 2025 to May 2026

This section includes extracts from the latest report on Clinical Supervisors who attended the SWAT Training from February 2025 to March 2026. One of the most significant achievements of the SWAT programme has been its ability to reach a large and diverse audience of clinical supervisors across South Africa.

Through both face-to-face and online delivery, the programme has engaged supervisors from multiple universities, training platforms, clinical disciplines, and healthcare settings. Participants have included academic clinicians, programme coordinators, heads of department, educational leaders, and frontline clinical supervisors responsible for registrar training.

The transition to blended and online delivery substantially expanded the programme's reach by reducing geographical and logistical barriers to participation. This enabled supervisors from urban, rural, academic, and service-based settings to access faculty development opportunities that may otherwise have been unavailable.

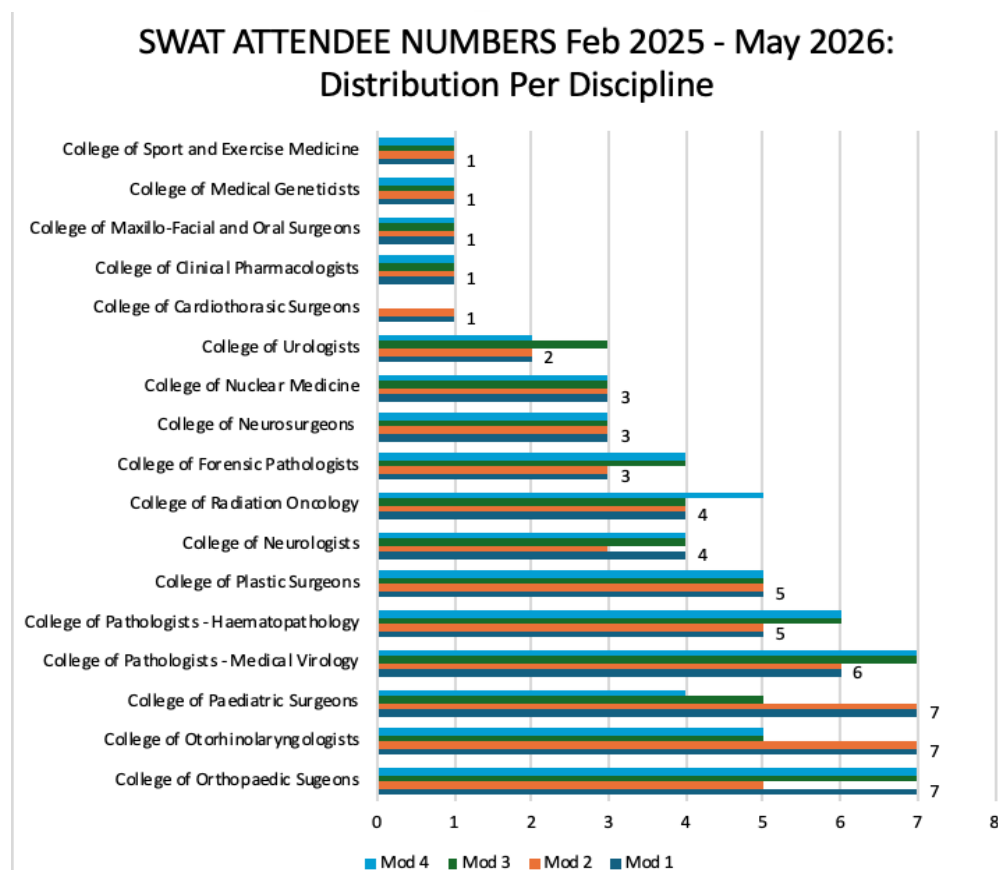
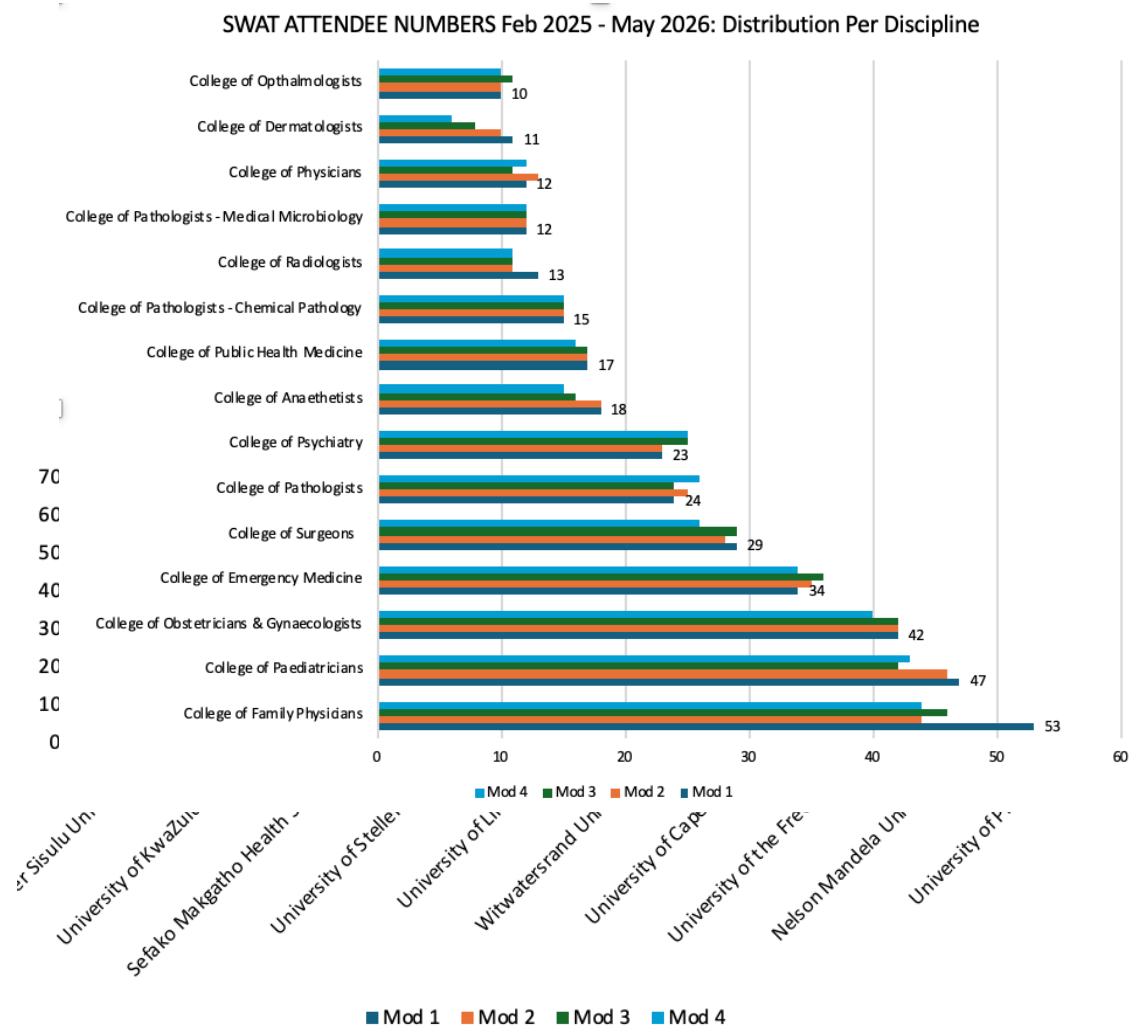
Importantly, the programme has fostered interdisciplinary engagement. Rather than restricting participation to individual specialties, SWAT has created opportunities for supervisors from diverse clinical disciplines to learn together, discuss common challenges, and develop a shared understanding of workplace-based assessment. This has contributed to the development of a more cohesive national approach to competency-based postgraduate training.

1 Face-to-Face Trainings

Due to the modular nature of the training (four modules of three hours each), clinical supervisors may not yet have attended all 4 modules.

Attendees of the SWAT Training across South Africa 2025 to May 2026 – per module			
	2025	Jan – May 2026	Total
Module 1	377	57	434
Module 2	376	55	431
Module 3	377	48	425
Module 4	363	49	412

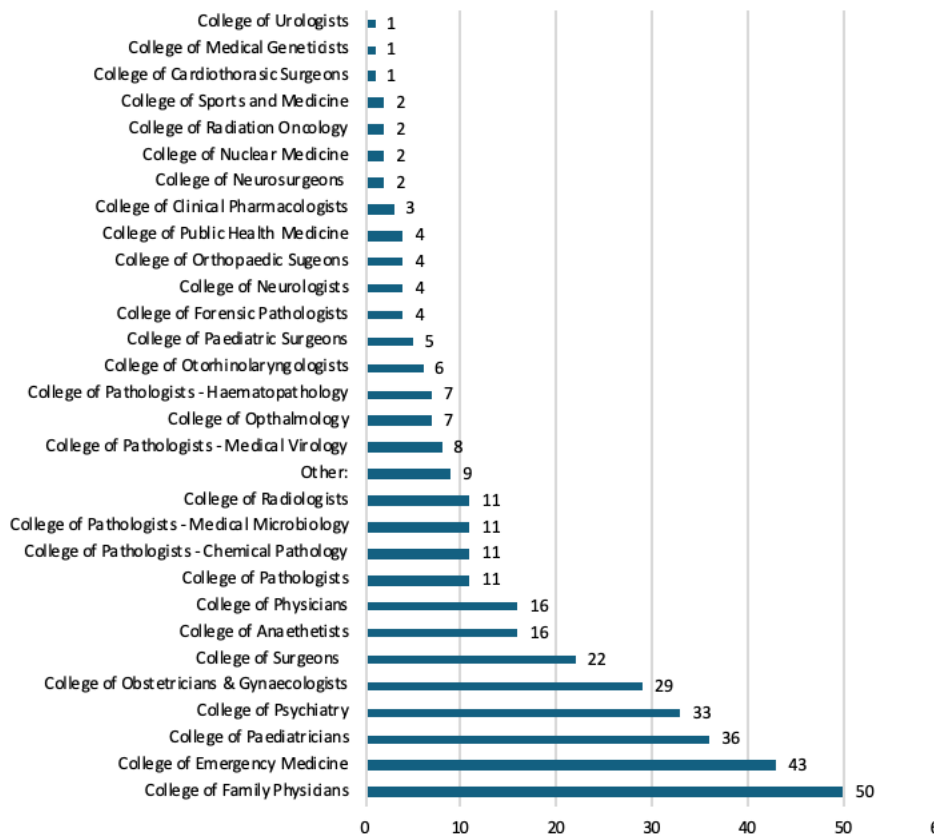
Below is the distribution of attendees of the 4 modules per discipline. It is noteworthy that 32 of the 33 Colleges of Medicine have had at least 1 person attending.



2 Learn@CMSA: Asynchronous Online Learning

370 participants registered in 2025 for on Learn@CMSA for the asynchronous part of the SWAT Training, and 173 have registered for 2026 up to date.

SWAT: Resistrations on CMSA per Disciline 2025



3 SWAT Online Webinar

The 1st iteration of the CMSA SWAT Online training took place from 25 February until 3 May 2026, with the 4 webinars held on 4 March, 18 March, 8 April, and 22 April 2026, respectively. 397 participants registered via JotForm;

Registered for each webinar:

135 (Module 1), 100 (Module 2), 88 (Module 3), 88 (Module 4)

Participants per webinar: 149 (Module 1), 109 (Module 2), 96 (Module 3), 88 (Module 4)

Participants eligible for badges for attending webinars in full: 93 (Module 1), 68 (Module 2), 62 (Module 3), 49 (Module 4)

28 participants completed all 4 online webinars and all of the asynchronous modules as of May 2026.

SWAT Programme Evaluation

Since its inception, the SWAT programme has been guided by a commitment to evidence-informed educational practice and continuous quality improvement. Evaluation has therefore been embedded within the programme from the outset, not only to assess participant satisfaction, but also to understand how the programme influences knowledge, attitudes, behaviours, educational practice, and ultimately the implementation of workplace-based assessment across South Africa.

The SA-SWAT-C has used multiple sources of evaluation data, including participant feedback surveys, webinar evaluations, facilitator reflections, attendance records, implementation experiences, and informal feedback from clinical supervisors and educational leaders. Collectively, these data provide evidence of impact at individual, institutional, and national levels.

The SWAT training course evaluation completed at the end of each module consistently scored between 4.3 and 4.8 out of 5 (on average across all responses) for all aspects of the training, indicating high satisfaction. Included below is the latest evaluation report for the CMSA online webinar training.

Evaluation of the CMSA online Webinar February to May 2026					
Evaluation Aspect: Lickert Scale 1-5 (Question)	Module 1 (91 responses) WBA 101	Module 2 (64 responses)	Module 3 (64 responses)	Module 4 (52 responses)	Overall Average
Important Clinical Supervisor related issues were addressed in this module and webinar	4.37	4.63	4.78	4.52	4.58
Key concepts were effectively and clearly conveyed	4.45	4.42	4.66	4.46	4.50
The slides were informative and easy to understand	4.41	4.39	4.69	4.62	4.53
The exercises were useful and contributed to my skills in this area.	4.19	4.17	4.55	4.52	4.36
The Facilitator was knowledgeable and well-informed	4.82	4.70	4.89	4.69	4.78
I gained useful knowledge and/ or skills	4.41	4.44	4.73	4.62	4.55
I am likely to participate in activities related to the issues raised in this webinar	4.49	4.55	4.75	4.58	4.59
The meeting was well organised	4.63	4.63	4.77	4.60	4.66
My time was well spent attending this webinar	4.42	4.44	4.69	4.52	4.52

Participant evaluations have consistently demonstrated high levels of satisfaction with the programme.

Participants frequently describe the workshops as practical, relevant, engaging, and immediately applicable to their educational roles. Interactive activities, simulation exercises, small-group discussions, and opportunities for reflection are repeatedly identified as particularly valuable aspects of the curriculum.

A notable finding across evaluations has been participants' appreciation of the balance between educational theory and practical application. Supervisors report that the programme helps them understand not only what workplace-based assessment is, but also how to implement it effectively within the realities of their own clinical environments.

The emotional competence module, feedback simulations, and Clinical Competency Committee exercises are consistently rated among the most impactful learning experiences. Many participants describe these sessions as transformative, challenging them to reconsider their assumptions about supervision, assessment, and learner development.

PART 1 REFLECTIONS

1.1 Reflection on Students

The most significant feature of the target group for the SWAT Training is its diversity. Any medical doctor working in a clinical environment, with registrars, provides mentoring, support, and advice. Clinical supervisors come from diverse backgrounds, ages, personality types, and attitudes. Some may find supervising trainee doctors an additional burden. A key challenge is the wide variety of knowledge and experience in mentoring. Mentoring and supervision are not skills that are taught, assessed or well understood in the medical profession. Doctors often mentor others in the same way they were mentored. Some doctors are excellent teachers and provide a supportive learning environment, whilst others are dismissive and rude, contributing to a toxic workplace (Olasoji, 2018). We also reflected on the diverse needs' trainees may have in the classroom, with different learning styles, personalities and neurotypes. Even the disciplines themselves differ in their approach to training, with paediatricians tending to be more reflective and surgeons more pragmatic.

Our training content needed to be standardised to ensure we offer the same product across all disciplines and universities, while remaining flexible enough to adapt to different settings and accommodate the needs of different types of trainees. This included the challenge that clinical supervisors are, first and foremost, hardworking clinicians, and we needed to consider the time commitment that would be feasible.

The SA-SWAT-C considered interactive, innovative content essential to creating space for diverse ideas and different ways of learning. It was impossible to finalise this as a theoretical

concept, and the pilot master training in February 2025 was instrumental in testing out different educational activities. The group represented different geographical locations and disciplines and provided input on what they considered would work best in their settings. We adopted a growth mindset, considering each trainee as having the potential to learn, and providing an opportunity in the training for reflections that could be continued within their working environments (Ramani et al., 2019).

During the Face-to-Face workshops in 2025, evaluation forms were completed by participants at the end of each training. These inputs were considered when reviewing the SWAT training for 2026. The CMSA online-webinar version hugely increased access for busy clinicians who could not take time out of busy clinical environments to attend full time trainings during the day.

The initial SWAT training was focused on exposing all of the disciplines across the universities and was mostly attended by early adopters. The training material, and particularly the role play and interactive examples, were still mostly drawn from the discipline of family medicine, as the original TCT training originated from there. As other disciplines became involved, and the SA-SWAT-C also included TH from ENT and VS from Surgery, a need was identified for discipline specific SWAT trainings. Using the Online Webinar platform, the existing SWAT training could be adapted to include examples and exercises from that specific discipline. MM is in the process of creating a guide on how to put together a discipline specific SWAT package. The online webinars can be scheduled at times that suit that particular discipline and its modular approach reduces the interruptions to clinical time.

One of the most significant achievements of the online adaptation was its ability to expand access to faculty development across South Africa. The blended model enabled participation by supervisors who may previously have been excluded because of geographical location, service commitments, travel costs, or institutional constraints. Clinicians from multiple specialties, training institutions, and healthcare settings were able to engage in shared learning experiences without the logistical challenges associated with face-to-face attendance.

1.2 Reflection on Collaborative Teaching Context

COVID-19 changed the classroom setting irrevocably. Prior to 2019, most medical training was restricted to face-to-face interactions. This made training lengthy, costly and provided challenges to access in remote and resource-restrained settings. This would be a novel training program, as it would span multiple universities and disciplines. In the medical field, disciplines often work in silos, with each university having its own approach to registrar training. Even within one university and discipline, there may be different ways of teaching. For example, at Walter Sisulu University, some family medicine registrars are placed at rural

district hospitals for their entire training, whilst others might be at a large regional hospital and complete rotations through departments such as obstetrics, paediatrics and mental health. Each of these settings have their own particular clinical learning environment.

To implement a training program, we needed political buy-in. We already had the commitment of the CMSA and SACOMD, who recognised the training of clinical supervisors as a key task in the roll-out of WBA. Following the pilot, we finalised the course content into a 24-hour training package. The National WBA committee agreed to accredit the training, with certificates signed by the CMSA and SACOMD. An important part in the roll-out of the SWAT training was engagement with the Deans and HOD at the different universities. SACOMD engaged with the Deans, providing them with reports and updates on the progress of the SWAT rollout. The SA-SWAT-C each interacted with the HODs at their respective universities: MM at WSU and NMU, RC at WITS, VS and MN at UKZN, TH at UCT, HB at UFS, and BM at SU. The SWAT training would be positioned as a necessary requirement for all clinical supervisors. At first, it will be voluntary, but the aim is to for it to become compulsory for any clinical supervisor who does WBAs on registrars.

We still considered face-to-face contact the ideal teaching setting, and could limit the time commitment by adding distance-learning components. During Phase 1, we therefore rolled out the SWAT as a hybrid training with 2 days face-to-face and an additional 12 hours done asynchronously on the Learn@CMSA online platform.

During Phase 1 we reflected as a team on the attendance and engagement at the face-to-face trainings. The evaluation was overwhelmingly positive for all 4 modules, but attendance was variable with one university only managing to attract 4 participants. Small departments found it impossible to release a clinical supervisor for a full 2 days. In provinces such as the Eastern Cape, clinical sites were scattered over a huge geographical area, and clinicians found it difficult to travel to attend.

There was also variable buy-in from different disciplines. Family Medicine and the surgical disciplines such as Obs & Gynae, Surgery and Emergency Medicine were keen to implement WBA, with HODs willing to release Clinical supervisors to attend the training. Some disciplines ensured representation at each training, and others did not engage at all. The CMSA online webinar version has massively increased the reach of SWAT training and enabled the creation of discipline-specific SWAT Training.

The other level of engagement is at the Colleges of Medicine level, and this area still needs further improvement. Each discipline is in the process of writing its own Entrustable Professional Activities and is at different stages of rolling out WBA. The Colleges need to engage with their discipline at each university to identify relevant clinical supervisors and

encourage clinicians to attend SWAT training. MM, RC, TH, and MN will assist Colleges in creating discipline-specific SWAT training.

1.3 Reflection on Knowledge

A key discussion the SA-SWAT-C had early on was how to shift clinical supervisors' attitudes. It would be relatively easy to teach the didactic concepts of workplace-based assessment, and the clinical skills required for effective feedback are not difficult to demonstrate. We wanted to foster supportive, encouraging and capable clinical supervisors, and for this, we would have to shift paradigms and change underlying attitudes. We were not worried about doctors who were already providing excellent mentoring, but about how to teach those who had themselves witnessed poor behaviour modelled in their own training and had been trapped in toxic learning environments throughout their careers.

We considered several learning theories to assist. Maslow's transformative learning theory describes the need for a disorienting event that challenges a person's existing beliefs about the world. Trainees encounter such dilemmas in clinical practice on a regular basis, but need guidance in reflecting on what these encounters mean and in being challenged about outdated beliefs (Hart et al., 2025). It is unrealistic to create such a dilemma during training and would require skilled facilitators, but we considered how to draw on existing discomfort with current training platforms to inspire change.

Kolb's experiential learning theory was a key part of our discussion (Kolb, 2015). We could not consider our short 2-day training as a single, stand-alone event, but rather as an opportunity for trainees to reflect on their current training and the learning environments they find themselves in. We wanted clinical supervisors to reflect on and learn from experiences out of the clinical environments.

An interesting debate was on whether 'attitude' or 'socio-emotive skills' could be taught in a classroom setting. There is still much debate in the literature about whether qualities such as emotional intelligence can be taught (like a skill) or are inherent traits (Brasseur et al., 2013; Mikolajczak, 2009). The SA-SWAT-C had more than 100 years of experience in teaching junior doctors between them, and based on this, agreed that most doctors can improve their behaviour, with the most powerful influencer being colleagues' role modelling in the workplace. The challenge that poor mentoring practices are still rife in postgraduate registrar training (Fluit et al., 2013). It was not possible in a short course to provide the kind of mentorship and role modelling that could shift behaviours over time. Our focus was therefore on motivating and inspiring clinical supervisors with a vision of a different way of training registrars. Adult learners learn best through experience (action) and then reflection on that experience (Taylor & Hamdy, 2013). We would achieve this by reflecting on the challenges they face in current

practice, and providing practical skills on how to change this. For this, we had to introduce innovative and powerful transformative reflection exercises.

We used a variety of educational strategies in each module. We will outline the activities we chose, why we chose them, what we discovered, and how we adapted them for online use in the next section.

1.4 Reflection on Professional Growth

The development of each module provided its own opportunities for innovation and growth. We describe our pathway below.

Module 1: Workplace-based Assessment 101 (See Addendum B)

The first module includes a certain amount of didactic teaching to cover concepts related to WBA, EPAs, the ePortfolio, and clinical competency committees. Recognising that abstract discussions of assessment theory are often insufficient to change practice, the SA-SWAT-C adopted an experiential learning approach. Participants are encouraged to engage actively with authentic scenarios, reflect on their own assumptions, and explore how workplace-based assessment might function within their specific clinical contexts

The Bouncing Baby Babysitter Academy Exercise

One of the most innovative features of this module is the “Babysitter Exercise,” which introduces the concept of entrustment through an everyday scenario rather than a clinical example. In WBA, assessments are made to make entrustment decisions (Gin et al., 2024). Rather than assessing the registrar on how competently they did, e.g. the procedure, the focus is forward-looking. How much would I trust this registrar to do this procedure in the future? Would I be willing to let them watch, or to assist in surgery, or do the surgery whilst I assist, or am I happy to leave the theatre as long as I am in the building, or am I happy to go home? In medical education, there is a huge emphasis on competence and marks – either you pass or fail. Although we make trust decisions all the time when we ask junior doctors to consult, using them in assessment is a radical paradigm shift. HB proposed and piloted a non-medical exercise to demonstrate this principle and MM adapted it further into an exercise that can engage the hearts and minds of the participants. The Bouncing Baby Babysitter Academy Exercise is now the first exercise of the training and participants are asked to imagine leaving their 6-month-old baby overnight with a newly qualified babysitter. Participants are divided into groups and asked to consider which educational activities and assessment methods will increase their trust in the babysitter’s ability to look after their baby.

Phase 1: The exercise consistently generates lively discussion and enables participants to identify many of the factors that influence entrustment decisions, including competence,

reliability, integrity, prior experience, context, and risk. Importantly, participants discover these principles for themselves before they are introduced to the formal educational theory underpinning entrustment.

Phase 2: For the CMSA SWAT online webinar training, it was felt that this session was key to include. The SA-SWAT-C met before the training to reflect on the various interactive components. It was felt that this was a key exercise to include. We decided to divide the group into breakout rooms, but it was important to have a facilitator in each to prompt discussion and provide concise feedback in the plenary. We asked for any SWAT trainer (not just from the expert group) who had availability to assist. TH facilitated this session with other team members available to field questions. Close to 100 people attended this webinar, and we were able to break into 8 break-out rooms, each with its own designated SWAT Trainer.

This activity has become one of the most memorable components of the SWAT curriculum. Participant evaluations frequently identify the exercise as a key moment in understanding the concept of entrustment, illustrating the value of using relatable analogies to explain complex educational constructs.

WBA in Action exercise

The second shift in attitude that needed to happen among clinical supervisors concerned the feasibility of conducting WBAs in busy clinical settings. The clinical supervisors all agree that observing registrars in the workplace and providing effective feedback are essential for registrar training. The biggest concern is the time commitment required to record each observation. The National WBA committee has been simplifying and operationalising a tool to capture WBA. TH's ENT department at UCT had already been piloting an app to capture WBAs on phones. The form captured some of the details (date, who, when, type etc.) of the WBA and the clinical supervisor is only required to fill in 4 field: An entrustment decision, narrative feedback on what went well, what could have been done better and an action plan on how to narrow the gap between observed and expected performance.

Phase 1: For the exercise, we created a jotform version of the WBA tool. We play a 3-minute video simulation of a first-year registrar doing a consultation (a simulation), in which the registrar clearly underperforms. Participants are given an opportunity to provide feedback using the WBA tool (accessed through a QR code). This exercise stimulates discussion and participants are encouraged to reflect on the use of such a tool in the clinical setting.

Phase 2: This exercise was relatively easy to translate to an online webinar. The participants were shown the same video and then asked to complete the tool (while still in the larger group). Participants are then divided into breakout rooms. For this exercise, we divided them up into disciplines that share similar styles of working (e.g. the surgical disciplines together). They are

asked to share and discuss their entrustment decisions, and then to reflect on the implementation of such a tool within their discipline.

The online adaptation retained the interactive and reflective nature of the original workshop and demonstrated that meaningful faculty development could occur in virtual environments without compromising educational quality.

Educational Impact

Evaluation data have consistently demonstrated the effectiveness of this module. Participants report increased understanding of workplace-based assessment, greater confidence in making entrustment decisions, and a clearer appreciation of the educational purpose of WBA. Many identify the practical exercises as particularly valuable because they provide concrete examples of how workplace-based assessment can be integrated into everyday clinical practice.

By combining educational theory, experiential learning, simulation, and reflective discussion, the WBA 101 module establishes a strong foundation for the remainder of the SWAT programme. It enables participants to develop both the conceptual understanding and practical skills required to engage effectively with workplace-based assessment and creates readiness for the more advanced topics explored in subsequent modules.

Module 2: Know Yourself, Your Registrar and Your Environment (Addendum C)

The second module of the SWAT programme represents one of its most innovative and distinctive features. While many faculty development programmes focus primarily on educational techniques, assessment processes, and feedback skills, this module addresses a more fundamental question: *Who do we need to be as clinical supervisors if we wish to develop competent, compassionate, and trustworthy specialists?*

A Novel Conceptual Framework in fostering ‘attitudes’

MM proposed an innovative perspective that draws on a neurophysiological understanding of stress and its impact on behaviour (Chamine, 2012). When human beings are in stress mode, the body generate specific negative emotions that trigger certain behaviours: fear is the biological impulse to move away from threat, anger is the biological impulse to destroy and obstacle in your way and distress is the biological impulse to cry out when lost or ashamed (Panksepp, 1998). These biological impulses translate into specific counter-productive behaviours as a subconscious attempt to manage the difficult emotions. Chamine (2012) has created a simple model that describes 10 of these counterproductive emotions, including criticising, manipulating, one-upping, preaching, pleasing, obsessing, worrying, avoiding, self-pitying and distracting oneself with e.g. substances (Figure 1). This theory posits that clinical

supervisors who are rude, dismissive, avoidant and who humiliate and belittle their registrars, are in stress mode and are not aware of the impact of these subconscious impulses on the relationships with those around them. It also helps to explain the dynamics that create toxic working environments and the behaviours demonstrated by the registrar who may be in difficulty.

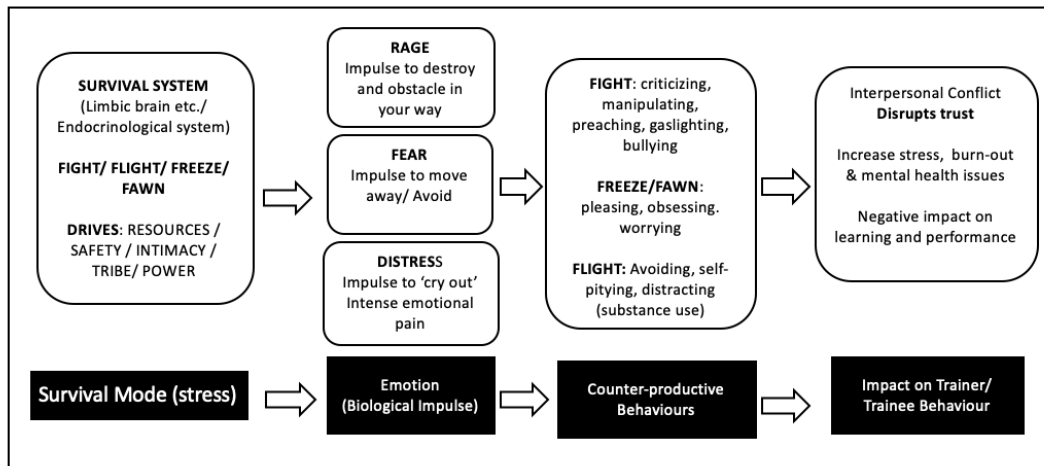


Figure1 : The influence of stress on emotion and the behaviour of the trainer/ trainee. (From Chapter 2: Trust and entrustability in medical specialist training in South Africa: An Ubuntu-inspired pedagogy - not yet published)

If we therefore want clinical supervisors to display the type of qualities we want to train in registrars, such as agency, reliability, humility and integrity (ten_Cate & Chen, 2020) and qualities encapsulated in ubuntu, such as compassion, openness (non-judgment) and curiosity (cultural competence), they need to develop a high level of emotional competence. Engaging from the executive self (non-stressed brain) enables access to higher functions such as reflection, empathy and inhibitory control (Figure 2).

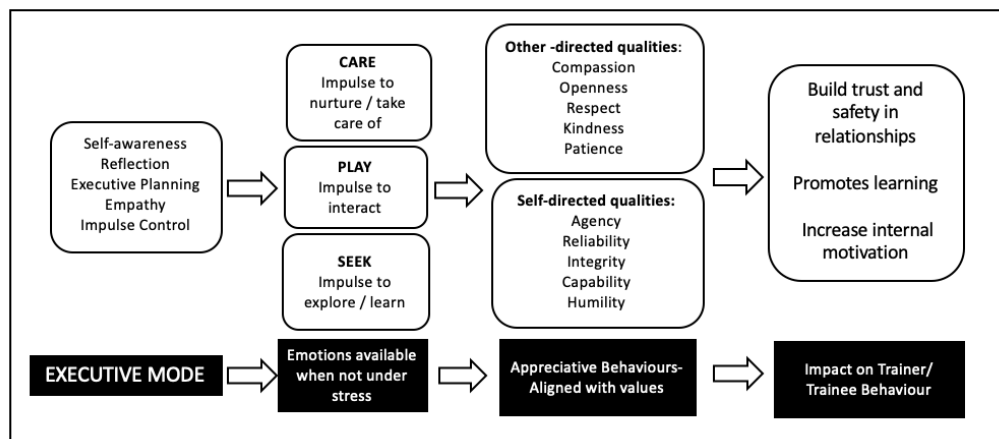


Figure 2: The executive function of the brain and its impact on emotion and the behaviour of the trainer/ trainee. From Chapter 2: Trust and entrustability in medical specialist training in South Africa: An Ubuntu-inspired pedagogy - not yet published)

We propose that an emotionally competent clinical supervisor who has emotional insight (understanding how emotion drives behaviour), emotional awareness (noticing when strong emotions are triggered in real time) and emotional regulation (effectively managing emotions and behaviours as they arise) can provide supportive, appreciative and insightful feedback. The focus of the SWAT training is therefore not to teach clinical supervisors why they should be kind, but to help them develop the emotional skills they need to ensure they engage with their students from their best selves.

This conceptual framework was initially explored during MM's MPhil in Health Professions Education and subsequently expanded through collaborative scholarly work by MM, RC, VS, and TH. The framework now forms part of the forthcoming book *Trust and Entrustability in Medical Specialist Training in South Africa: An Ubuntu-Inspired Pedagogy*, currently undergoing final revision for publication.

The 2nd module of the SWAT training focuses on providing clinical supervisors with a better understanding of what drives difficult behavior and interactions at work, practical exercises on building emotional awareness and tools on how to manage strong emotions in themselves and others. Participants are provided with a worksheet and exercises to capture their reflections.

Exercise 1: The Ubuntu Self-reflection exercise

Prior to attending the session, participants complete a self-assessment designed to identify common counterproductive behavioural patterns that emerge under stress. During the workshop, participants are invited to reflect on a challenging interaction with a registrar or trainee and analyse the encounter using a structured four-step process. They explore the emotions, assumptions, behaviours, and outcomes that influenced the interaction, both for themselves and for the trainee involved.

The exercise encourages participants to move beyond simplistic explanations of workplace conflict and instead consider the deeper emotional and relational dynamics that shape behaviour. Through this process, supervisors often gain new insights into their own responses to stress and the impact these responses may have on learners.

Participant evaluations consistently identify this exercise as one of the most powerful components of the programme. Many report that the insights gained extend beyond educational practice and positively influence relationships with colleagues, family members, and others in their personal lives. The exercise has undergone several iterations and refinements and has become a defining feature of the SWAT curriculum.

Exercise 2: Unconscious Bias and Power

Clinical supervision occurs within social structures shaped by power, privilege, identity, and culture. This exercise encourages participants to reflect critically on how these factors influence their perceptions of trainees and their educational decision-making.

Using guided reflection activities, participants explore the concepts of power, marginalisation, and unconscious bias. Particular attention is given to how assumptions about race, gender, language, culture, socioeconomic status, and professional identity may influence supervisory relationships and assessment decisions.

The exercise is intentionally designed as an awareness-building activity. Although limited by time constraints, it provides an important foundation for ongoing reflection and contributes to the development of more equitable and inclusive educational practices.

Exercise 3: Emotional Regulation – Managing stress

This practical exercise introduces participants to evidence-informed strategies for managing stress and emotional activation in real time.

Healthcare professionals frequently work in environments characterised by uncertainty, high workloads, emotional intensity, and interpersonal conflict. Such conditions can impair decision-making, communication, and learning. Through guided mindfulness and awareness exercises, participants are introduced to simple techniques that can be used to interrupt stress responses and regain emotional balance.

Although many participants are familiar with mindfulness in theory, few have considered its application in clinical supervision, feedback conversations, and workplace conflict. This exercise, therefore, bridges the gap between personal well-being and educational practice.

Exercise 4: Identifying and Transforming Toxic Work Environments

Participants are introduced to the concept of toxic work environments and how it links to medical error, poor learning, burnout, and mental health complications in healthcare workers. In the context of feedback, we aim for affirmative, supportive environments in which trainee clinicians feel safe asking questions and admitting mistakes (Donaldson et al., 2000; Ramani & Krackov, 2012). This exercise invites participants to reflect critically on the characteristics of their own learning environments and to consider how workplace culture influences feedback, supervision, and trainee development. Through facilitated discussion and anonymous polling, participants explore issues such as psychological safety, hierarchy, humiliation, exclusion, and workplace mistreatment.

One of the most striking findings emerging from this exercise is the consistency with which participants report experiences of toxic or degrading workplace environments. Across multiple workshops, more than half of participants have identified significant challenges within their own settings. These discussions often become powerful moments of collective reflection and reinforce the importance of developing educational leaders capable of fostering healthier workplace cultures.

Exercise 5: Appreciative Inquiry

Providing feedback on poor performance remains one of the most challenging aspects of clinical supervision. This exercise introduces participants to the principles of Appreciative Inquiry as a framework for conducting constructive, developmental conversations. Participants are taught how to turn a negative statement (such as “You are always late for work”) around, then asked to think of a difficult issue they need to broach with a registrar and how to phrase it. There is never enough time to do this exercise in enough depth and it can easily be an hour session on its own.

For the online webinar version, we ask people to post their revised ‘opening statement’ to the registrar in the chat, and it is clear that many struggle to avoid depreciative language. In the last online webinar, MM presented a real-world scenario, which seemed to improve the output. It was interesting to note how the trainers are continuously learning from each other. After this session, RC reflected that he had not yet tried this particular exercise and that a scenario at work may benefit from it.

Phase 1: This is the module that has needed the most change and refinement throughout 2025. Some exercises had to be culled, the worksheet had to be updated and language and analogies adapted.

Phase 2: This module has translated remarkably well to the online webinar format. There are no break-out rooms, but participants can interact via Zoom polls. The exercises are done as personal self-reflections.

Educational Impact

This module has undergone continuous refinement since its introduction and has become one of the most highly rated components of the SWAT programme. Participants consistently describe it as transformative, reporting increased self-awareness, improved communication skills, greater empathy for trainees, and enhanced capacity to manage difficult workplace interactions.

More broadly, the module challenges traditional assumptions about faculty development by positioning emotional competence as a foundational educational capability rather than a peripheral personal attribute. In doing so, it expands the conversation about what constitutes excellence in clinical supervision and offers a novel approach to developing the qualities required for effective workplace-based assessment, entrustment, and educational leadership.

The success of this module demonstrates that faculty development can address not only what supervisors do, but also how they think, relate, and lead within complex clinical learning environments.

Module 3: Effective Feedback (See Addendum D)

The aim is to ensure that clinical supervisors understand what constitutes good feedback and why a relationship of trust is essential for effective feedback (Boud, 2015). Feedback must consistently meet the trainee's needs and focus on important performance points (Norcini & Burch, 2007). To teach high-quality feedback, we must clarify what we mean by 'feedback' and 'high-quality'. Boud (2015) highlights the importance of our recent change of focus in defining feedback, considering not only the inputs but also their effects. An updated definition of feedback, according to Boud is *'...a process whereby learners obtain information about their work in order to appreciate the similarities and differences between the appropriate standards for any given work, and the qualities of the work itself, in order to generate improved work.'*

Certain conditions must be met for feedback to be optimal: Learners must value the input, a dialogue between the given and receiver must be established to appreciate the criteria that will be applied, trust must be established between the giver and receiver, and learners need to develop their capacity to calibrate their own judgements and identify how their work needs to be approved (Boud, 2015). This means we are not only teaching clinical supervisors how to give feedback, but they also need to understand how to build a supportive environment and a relationship of trust in which feedback can be effective.

We used Ramani and Krackov (2012) twelve tips on providing high-quality feedback to structure this module, which considers this feedback loop and focuses on feedback technique. Feedback starts with a learner's self-assessment, and the clinical supervisor first reinforces correct behaviours before discussing areas of improvement. Any feedback session concludes with an agreed action plan for the future (Ramani & Krackov, 2012).

Pendleton Rules, which first asks students to reflect on their learning before giving feedback, is an easy-to-use, practical feedback model (Orsini et al., 2022) that incorporates many of the recommended feedback tips.

The first part of the module covers the didactic aspects of feedback (as highlighted above) and introduces the key feedback models. It was also clear that this needed to be an interactive,

practical workshop. We benefited from the experience of the SAAFP TCT trainers, HB, RC, and BM, who had been using role-play to teach effective feedback to family physicians. They had created a role-play exercise where people were divided into groups of three. The first two will 'play act' a scenario in which a registrar is conducting a consultation with a patient. The third person will role-play a clinical supervisor and provide feedback to the registrar using the Pendleton Rules. The patient would then provide feedback to the clinical supervisor (again using Pendleton).

Feedback Roleplay exercise

Phase 1: A significant innovation introduced during the development of SWAT was the creation of scripted role-play scenarios. Early iterations of the workshop revealed that participants sometimes became distracted by the clinical content of scenarios rather than focusing on the feedback process itself. To address this challenge, MM developed structured scripts that provided standardised scenarios and dialogue.

The participants were again divided into groups of 3, but this time each scenario (registrar with a patient) was already written out, and the two participants had to simply read the script. The third person would then provide feedback to the registrar. This reduced the pressure on participants performing the roleplay and also gave us the opportunity to role-play specific challenges, such as unsafe or inappropriate behaviour by the registrar. The biggest challenge with these scenarios is that they are very family medicine-based.

Participants enjoy this exercise immensely, and it stimulates extensive discussion and reflection. The three scenarios ensure that everyone has an opportunity to practice.

Phase 2: This was the most difficult exercise to translate into the online webinar space. RC has been facilitating the CMSA online webinar. We had already noted in the face-to-face settings that it needed a lot of facilitator input to keep the group on track. MM piloted an innovative educational strategy using video. She used the same simulation video of the registrar doing a consultation, but added another video where the registrar provides self-reflection on her performance (as per a Pendleton). The group was then divided into breakout rooms of about 8 to 10 people. We aimed to have a facilitator in each group. Each person was asked to write out their feedback as they would give it to that registrar (What went well, what could have been done better and the action plan). They were then asked to read out their feedback. The Facilitator would provide appropriate 'feedback on their feedback.'

The method did work and there was positive feedback from participants on the practicality of the workshop, but it does feel that we can potentially improve this further. One challenge is the very family medicine-specific scenarios, and we need to develop scenarios appropriate for the different disciplines. This workshop is consistently one of the highest-scoring on the

evaluation form, as it provides the clinical supervisor with skills they can immediately use in the clinical environment.

Module 4: Entrustment: Ad Hoc and Summative (See Addendum D)

The fourth module addresses one of the most conceptually challenging aspects of workplace-based assessment: entrustment decision-making and the role of Clinical Competency Committees (CCCs). While supervisors generally understand the principles of observation and feedback, many find it more difficult to understand how multiple workplace-based assessments are integrated over time to support high-stakes progression decisions.

This module was therefore designed to help clinical supervisors understand how individual observations contribute to broader judgements about competence, readiness for independent practice, and progression through specialist training. It also introduces participants to the role of Clinical Competency Committees as a key mechanism for ensuring that assessment decisions are evidence-informed, transparent, and defensible.

Exercise: The CCC simulation exercise

The exercise was originally adapted from workshops developed by Professor Olle ten Cate and colleagues and was initially introduced to South African participants during the early phases of workplace-based assessment implementation. As the SWAT programme evolved, the exercise underwent extensive revision to ensure greater alignment with the realities of South African specialist training.

Participants are assigned roles as members of a Clinical Competency Committee and are provided with information about a registrar seeking progression or entrustment within a particular professional activity. Each committee member receives different pieces of information and perspectives regarding the registrar's performance, while the group is provided with a summary of portfolio evidence and assessment data.

Working collaboratively, participants must review the available evidence, discuss differing viewpoints, weigh competing considerations, and reach a collective decision regarding entrustment and progression.

Phase 1: This exercise was first introduced by HB, RC and BM and worked very well in the face-to-face setting.

Phase 2: This was a tricky exercise to adapt for the CMSA online webinar setting. MN, who serves on the National CCC, facilitated the CMSA SWAT online webinar. It did give us an opportunity to update the role-play material to better align with the South African setting. MM restructured the content and created a PowerPoint presentation that carefully outlined all the different roles. The participants were divided into breakout rooms by discipline, with an

experienced SWAT trainer in each to coordinate the meeting. The PowerPoint was used to guide participants through the initial roleplay, and then it was opened for discussion.

This exercise worked remarkably well online, and the feedback has been excellent. It feels like it needs further refinement, as it did not allow enough time for discussion afterwards.

Conclusion: Reflection on Educational Transformation and Social Justice

As the SWAT initiative evolved from a faculty development intervention into a national programme, one of our most significant insights was recognising that successful implementation of WBA required far more than training supervisors to use assessment tools. Initially, we assumed that the primary challenge was a lack of knowledge and skills. However, through implementation and engagement with clinical supervisors across South Africa, we realised that the barriers to effective supervision were often rooted in culture, relationships, power dynamics, and organisational systems rather than technical competence alone. This finding echoed our own scholarship, which demonstrated that the impact of WBA depends largely on the quality of supervision, feedback, and educational relationships rather than the assessment tools themselves.

This realisation fundamentally shifted our team's thinking. Rather than viewing SWAT simply as a mechanism to train assessors, we began to conceptualise it as a vehicle for broader educational transformation. Hence, the programme evolved to focus not only on assessment and entrustment, but also on emotional competence, psychological safety, trust, feedback culture, and reflective practice. These elements are increasingly recognised as central to transformative learning and effective clinical education. Our own research on digital feedback, learner engagement, and workplace-based assessment reinforced the importance of learner agency and developmental feedback in supporting meaningful learning.

As an interdisciplinary team working across institutions and specialties, we were also challenged to examine our own assumptions. We quickly recognised that educational solutions that appeared effective within one context were not always transferable to another. Differences between urban and rural training platforms, resource availability, institutional culture, and disciplinary traditions required ongoing adaptation. This experience taught us that educational innovation cannot be imposed through a standardised model; meaningful change requires responsiveness to context while maintaining a shared commitment to educational quality.

A particularly important reflection concerned educational equity. Traditional faculty development programmes often privilege educators working in well-resourced academic centres, while supervisors in rural or resource-constrained settings face significant barriers to participation. The decision to adapt SWAT for online delivery, therefore, became more than a

logistical solution, it became an intentional strategy to democratise access to faculty development. By creating flexible, modular learning opportunities accessible across the country, we sought to broaden participation and strengthen supervisory capacity nationally. Our reflections on social justice were further deepened through discussions around workplace culture. Across workshops, supervisors consistently described challenges relating to burnout, hierarchical relationships, poor communication, and psychologically unsafe learning environments. These conversations reinforced our understanding that educational quality cannot be separated from the conditions in which learning occurs. Registrars who learn in environments characterised by fear, exclusion, or intimidation are less likely to seek feedback, admit uncertainty, or engage fully in learning. Such environments disproportionately disadvantage learners who are already vulnerable due to social, cultural, or institutional factors. Consequently, we came to view the creation of supportive learning environments as a social justice issue rather than simply a pedagogical concern.

Another important area of learning concerned trust. Through SWAT, we came to appreciate that trust is not only central to entrustment decisions but operates throughout educational systems. Registrars must trust supervisors to provide fair feedback, supervisors must trust trainees with increasing responsibility, and institutions must trust supervisors to make sound educational judgements. This understanding has informed our emerging scholarship on trust, identity, relationships, and workplace learning within South African specialist training.

Perhaps our most important insight is that sustainable educational transformation occurs through relationships rather than regulations. Policies and assessment systems may provide the structures for change, but meaningful transformation depends on educators who are willing to reflect critically on their own practice, challenge assumptions, and create environments where learning can flourish. The SWAT programme, therefore, seeks not merely to train assessors but to cultivate a national community of reflective clinical educators committed to excellence, equity, and social accountability.

Looking back, the most significant achievement of SWAT is not the creation of a national training programme, but the creation of a shared vision for clinical supervision in South Africa. Through collaboration across institutions, disciplines, and professional backgrounds, we have sought to foster learning environments characterised by trust, feedback, reflection, compassion, and respect. While workplace-based assessment provided the catalyst, our broader aspiration has been to contribute to the transformation of postgraduate medical education and strengthen the quality, equity, and social accountability of specialist training nationally.