

Interprofessional supervision: strengthening clinical supervision by utilising commonalities across profession

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Abstract: All health professions are unified by having the client at their core. Clinical supervision provides healthcare workers with opportunities to work across professional boundaries. Interprofessional supervision occurs when the supervisee and supervisor have different professional backgrounds. Unpacking this concept is likely to enhance healthcare workers' understanding, and therefore its use. In this paper, the authors use the well-recognised Proctor's model of clinical supervision, to reflect on the tendencies of different professions to embrace different aspects of clinical supervision (e.g., direct and reflective aspects), and recommend strategies for healthcare workers from different professions to collaborate more in the supervision context.

Keywords: clinical supervision; interprofessional supervision; interprofessional competencies

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Introduction

Clinical supervision tends to be viewed through different lenses, depending on the profession and area of practice of the supervisee and supervisor. Whether stated or implied, the ultimate purpose of clinical supervision is threefold: to ensure client safety, to provide support for the supervisee, and to uphold clinical governance for the healthcare organization (Martin et al., 2014). All health professions, although trained differently and guided by different philosophies, are unified by having the client at the core of their service delivery. Increasingly, academic institutions and healthcare organizations are promoting interprofessional education and collaborative practice (IPECP), to enhance coordination of client care and better outcomes for clients, carers, and communities (Joosten-Hagye & Khalili, 2022). Two key reports were drivers for IPECP, namely the World Health Organization's 'Framework for action on IPECP' (WHO, 2010) and Frenk and colleagues' (2010) Lancet report on 'health professionals for a new century'. Both reports argued that continuation of siloed, discipline-centric practice is not going to be able to meet the future healthcare needs of the communities around the world. Unless professions collaborate and work together more closely, the reports highlighted that healthcare outcomes and workforce issues would remain a great challenge (Frenk et al., 2010; WHO, 2010). In response, several academic institutions introduced IPECP in their core curriculum for health professions, and healthcare organizations rolled out staff training and other initiatives to promote IPECP (Martin, 2022). Clinical supervision also presents opportunities for professions to utilize commonalities (Lindblad, 2021), in practice, training, and research.

Proctor's model of clinical supervision

A framework such as the Proctor's model of clinical supervision provides a starting point for health professions to examine potential commonalities in clinical supervision practice. Brigid Proctor first proposed the tripartite clinical supervision model based on her experience with probation and counselling (Proctor, undated as cited in Fowler, 1996). In this model, she identifies three domains or areas of supervision (Fowler, 1996). Often, the three domains of supervision tend to overlap, and it is best to consider them *fluid*. The three domains are:

1. Formative - the developmental role of supervision
2. Normative - the ongoing monitoring, evaluating, and assessing role
3. Restorative - the responsibility to ensure that the supervisee is adequately refreshed and supported.

Within the formative domain, the supervisor is said to address three functions, namely tasks (e.g., conducting an assessment, suturing, splinting), decisions (e.g., prioritizing clients, referring to the right healthcare worker), and reflective practice (e.g., reflecting on client discharge processes as part of an audit, managing a confused client during the night shift). Collectively, all three functions target the development of the supervisee's skills and knowledge (Fowler, 1996). The normative area concerns clinical governance and quality assurance, to ensure that the service delivery is safe and effective (Martin et al., 2014). This function at times could overlap with managerial duties carried out by a supervisee's line manager (Martin et al., 2014).

The restorative domain of supervision is dedicated to supporting the supervisee and ensuring their wellbeing at work (Milne & Reiser, 2020). Milne and Reiser (2020) have suggested six key competencies for supervisors to facilitate restorative supervision, namely

1. Developing the supervisee's personal coping strategies and professional competencies
2. Encouraging supervisees to build relationships (i.e., social supports)
3. Building and strengthening the supervision alliance
4. Challenging thinking errors of the supervisee and clarifying associated feelings
5. Providing constructive feedback and
6. Addressing interpersonal problems.

As clinical supervision is a two-way street, supervisees too are expected to possess certain competencies to make the most out of the restorative supervision provided by their supervisor. These competencies include:

1. Being ready for their work
2. Being professionally able and
3. Being interpersonally effective (Milne & Reiser, 2020).

Nancarrow and colleagues (2014), informed by a review of 17 supervision frameworks, showed the interconnectedness of different professional support approaches, such as clinical supervision, managerial support, and professional development opportunities. Interconnectedness, while promoting flexibility and diverse opportunities, may also compromise clarity resulting in confusion and ambiguity for a novice supervisee. Therefore, guidance and support are necessary for a novice supervisee to not only understand how all of these professional support approaches interact, but to also ensure they are receiving enough support in their role in line with organizational and professional requirements. A framework such as the Proctor's model can facilitate this, as this model has been widely used and accepted across different professional groups (Winstanley & White, 2003).

Professional differences in approach to clinical supervision

While the notion of collaborative practice may have purported benefits (client outcomes, organizational efficiencies, holistic approach), in practice, it may encounter barriers. These include historical teaching and learning practices in health professions which promote siloed approaches, thereby surfacing concerns about generalist training approaches which do not cater to the nuances of individual health professions and professional identity. Indeed, professional self-concept and job embeddedness, although considered protective against burnout (Goliroshan et al., 2021), may be a potential hindrance to interprofessional supervision (Box 1). Mental health services have long noted that employing profession-specific healthcare workers such as psychologists or nurses as generic mental health caseworkers can diminish their individual training and expertise, as it may restrict them practicing to their full individual profession's scope (Townend, 2005). Some professional registration boards (e.g., the Psychology Board of Australia, 2018) mandate profession-specific supervision for trainees and registrars. A balance needs to be achieved between respect for individual

Box 1: Interprofessional supervision

Interprofessional supervision occurs when the supervisor and supervisee engaging in clinical supervision have different professional backgrounds.

Box 2: Reflective supervision

Reflective supervision can occur both in the formative domain where it tends to be related to healthcare or service delivery, or in the restorative domain where it is related to the supervisee's mental health and wellbeing.

professions and respect for shared capabilities, goals and collaboration as systems that force interprofessional work while diminishing professional expertise and training can lead to a number of interprofessional difficulties (Townend, 2005).

Differences are known to exist between health professions in their preferred type and style of supervision. Some professions may lean towards more formative activities involving direct observation, focused on practical tangible learning outcomes (e.g., radiography, physiotherapy); while others engage more in restorative activities focused on reflection, self-compassion and managing burnout (e.g., social work, psychology). Some professions may lean more towards one style of supervision (e.g., observation), while others may lean more towards another (e.g., reflection) (Box 2), which may make crossing professional boundaries in supervision more challenging. This is important to address in supervision training, as effective supervision involves both aspects (i.e., direct, and reflective). Research has shown that professions that have a predominant focus on social and mental healthcare such as social work and psychology, prefer reflective supervision (Snowdon et al., 2020a). This type of supervision typically occurs away from the clinical environment and involves healthcare workers critically reflecting on their workplace experiences, identifying learning and development opportunities, and deconstructing both the cognitive and emotional aspects of their work role (Todd & Freshwater, 1999; Mann et al., 2009; Pearce et al., 2013). In contrast, professions with a 'hands-on' therapeutic clinical role, such as physiotherapy, occupational therapy, and speech-language pathology may prefer direct (i.e., observational) supervision (Snowdon et al., 2020a). In this model, the supervisor directly observes the supervisee's clinical practice and provides feedback and/or guidance on their care to facilitate clinical skill development within the context-specific environment (Paunonen, 1991; Cottrell et al., 2002).

Reflective supervision has a focus on both the cognitive and emotional aspects of the role, as such it is well-suited to addressing the emotional burden of healthcare workers' practice (i.e., restorative domain) (Proctor,

2010; Milne & Reiser, 2020). Evidence shows that reflective supervision can reduce healthcare worker burnout and work-related stress, including more recent but highly impactful stress related to the COVID-19 pandemic (Martin et al., 2021, 2022; Morelen et al., 2022). In theory, reflective supervision may also facilitate clinical skill development and the identification of gaps in client care, however there is an absence of evidence to support its effect on the quality of client care (Snowdon et al., 2016, 2017; Lilienfeld & Basterfield, 2020). On the other hand, direct supervision involving observation or co-treatment approaches (i.e., formative domain) involves greater levels of interaction with the clinical supervisor within a context-specific environment and provides the supervisor with a more objective representation of the supervisee's clinical performance (Snowdon et al., 2017). As such, it is more suited to clinical skill development (i.e., formative domain) and has been shown to improve the quality of client care (Snowdon et al. 2016, 2017, 2020b). As a stand-alone domain, however, it has limited applicability to addressing the restorative component of the professional role, which is increasingly becoming vital due to the pandemic-induced stressors (Martin et al., 2022).

Differences in the preferred type of supervision may be explained by health professions' professional practice frameworks and healthcare settings they work in. Social workers and psychologists have been shown to favor more reflective learning, whereby they reflect on their feelings and emotions experienced during their practice (Katz & Heimann, 1991; Massey et al., 2011). Reflective practice is a core concept in these professions and well-understood, likely due to the pedagogical approaches used in their pre-qualification education (Ferguson, 2018; Lilienfeld & Basterfield, 2020). Whereas, occupational therapists, physiotherapists and speech-language pathologists prefer kinesthetic learning, where they learn through practice or situations (Katz & Heimann, 1991; Massey et al. 2011). For these professions, there is less focus on understanding emotions and more focus on analyzing and synthesizing information to form objective decisions (Titiloye & Scott, 2002; Stander et al., 2019). Anecdotally, it appears some differences between professions in supervision practices may also be influenced by the healthcare worker's area of practice (i.e., healthcare setting), rather than their professional background. For example, healthcare workers in mental health may embrace reflective supervision, while their counterparts working in non-mental health areas of practice (i.e., physiotherapists in private practice) may tend to prefer

direct supervision, in line with the more 'hands on' nature of work in these areas.

Despite their preferences for specific types of supervision, healthcare workers tend to acknowledge the benefits of both direct and reflective supervision. The 'hands on' professions have reported positive experiences with reflective supervision and acknowledged that it enhances learning (Maringer & Jensen, 2014; Redpath et al., 2015; Gardner et al., 2021). However, they have limited opportunities to use reflective supervision due to a range of barriers. These include lack of conceptual clarity regarding reflective practice, lack of specific training on how to facilitate this, lack of facilitation of reflective practice during supervision sessions, and workplace demands restricting time for reflective practice (Coty et al., 2015; Knightbridge, 2019; Ziebart & MacDermid, 2019; Guy et al., 2020). Similarly, professions that have a predominant social and mental health focus express a willingness to participate in direct supervision (Gonsalvez et al., 2002) and those who incorporate components of direct supervision into their clinical supervision (i.e., supervisors observing video recorded treatment sessions) have reported marked improvements in their clients' mental health outcomes (Bambling et al., 2006). Therefore, healthcare workers are likely to benefit from a combination of direct and reflective supervision but need support to uptake their non-preferred type of supervision.

Applying interprofessional collaborative practice principles in clinical supervision

Key interprofessional education competencies:

1. *Role clarification* - understanding their own role and the role of other professions and using this knowledge appropriately to establish and achieve client goals.
2. *Team functioning* - understanding the principles of teamwork dynamics and group/team processes to enable effective interprofessional collaboration.
3. *Interprofessional communication* - healthcare workers from different professions communicating with each other in a collaborative, responsive and responsible manner.
4. *Patient/client/family/community-centered care* - seeking out, integrating, and valuing, as a partner, the input, and engagement of the client, family, and community in designing and implementing care and services.

5. *Interprofessional conflict resolution* - actively engaging self and others (including the client/family) in a positive and constructive way, addressing disagreements as they arise.
6. *Collaborative leadership* - understanding and applying leadership principles that support a collaborative practice model.

(CIHC, 2010).

Interprofessional Education and Collaborative Practice (IPECP), similar to clinical supervision, can enhance outcomes for healthcare workers, clients, and organizations (Frenk et al., 2010; WHO, 2010; Joosten-Hagye & Khalili, 2022). When professions move away from siloed approaches and collaborate more, errors in service delivery are reduced and client satisfaction increases (Reeves et al., 2010). Given more academic institutions are exposing the current generation of healthcare students to IPECP during their pre-qualification training, it is timely to investigate utilizing these principles within clinical supervision. For those untrained in or unfamiliar with IPECP, the Canadian Interprofessional Health Collaborative (CIHC, 2010) framework outlines six key competencies (Box 3):

Several resources exist that can provide information and guidance on IPECP competencies and ways of incorporating them into practice (Lindblad, 2021; Martin & Sy, 2021; Ford, Martin & Sy, 2022). Guidance also exists on applying the interprofessional philosophy in clinical supervision (i.e., interprofessional supervision). For example, Lindblad (2021), has outlined several ethical considerations of interprofessional clinical supervision for behavior analysts. This author has examined several potential risks in interprofessional supervision and has offered suggestions and recommendations to consider and mitigate them (Lindblad, 2021). Some potential risks include team members all not being on the same page given different legal and regulatory requirements (e.g., patient consent process, theoretical foundations informing practice, and data collection and storage), time constraints, reluctance to collaborate, and lack of knowledge and awareness about other professions. These considerations and recommendations are applicable for a wide range of professions beyond behavior analysis and could be a starting point for conversations about the applicability of interprofessional supervision to particular supervisees, supervisors, and work contexts.

Implications

Within interprofessional supervision, Proctor's model can be utilized by supervisees and supervisors as it lends itself to direct and reflective aspects. Similarly, shared supervision competency frameworks may allow healthcare workers to feel safe and well-informed to access interprofessional supervision where appropriate and additional profession-specific supervision as needed. Having a shared model of interprofessional supervision and a shared competency framework could address the three threats to effective interprofessional supervision, namely, professional embeddedness, overreliance on one aspect of supervision, and preference for one type of supervision activity.

Professions favoring direct supervision could benefit from professions that are well-versed in reflective supervision particularly in common practice areas. For example, a psychologist can guide a physiotherapist to explore their practice in a reflective manner: what went well or may have been improved about a treatment, engagement with a client or an experience in team functioning. These are shared areas of practice irrespective of one's professional background. Another example is where a physiotherapist shares their enthusiasm for direct supervision with the more reflective professions. Knowledge of the benefits of observation may encourage those with reflective supervision tendencies to engage in co-therapy or recorded sessions to benefit their skill development. Extending the same example, physiotherapists may be able to share interprofessional outcome tools, observation methods, evidence-based practice tools, clinical communication, management and leadership skills and shared care/ referral tools within interprofessional supervision.

Supervision which is inclusive of all domains of the Proctor's model, underpinned by direct and reflective aspects, is ideal. A checklist approach may be one mechanism to support the use of these elements for healthcare workers from diverse professions. [Davys and Beddoe \(2015\)](#) have offered practical suggestions for supervisees and supervisors to consider prior to setting up interprofessional supervision. We have adapted these suggestions and propose a checklist that could be used by supervisees and supervisors at the clinical supervision contracting stage ([Table 1](#)). This checklist is inclusive of critical elements of clinical supervision, easy to administer, and adaptable to different settings as required. This checklist would benefit from further testing in future studies.

Table 1:
Supervisee and supervisor checklist for interprofessional supervision (IPS)

Consideration	Supervisee	Supervisor	Additional information
What is your professional training and practice experience?			
What theoretical framework (e.g., models, approaches) do you use in practice?			
What are its implications for supervision?			
What professional codes, values, and ethics do you bring to supervision?			
How will you work through the differences?			
How do you view the supervision process - do you use a particular model (e.g., Proctor's model)? What functions (i.e., formative, normative or restorative) will IPS address?			
How will the supervisee address the other functions of supervision not covered in this IPS arrangement?			
What are the supervisee's professional development and overall supervision goals?			
What are the supervisee's specific goals for IPS?			
What are both parties' expectations of each other?			
How will disagreements be resolved if any arise?			
Who has clinical responsibility for the supervisee's practice?			
To whom is the supervisee professionally accountable? (e.g., professional manager)			
To whom is the supervisee organizationally accountable? (e.g., operational or line manager)			

Table 1. (continued)

Consideration	Supervisee	Supervisor	Additional information
How does this IPS arrangement interact with the three elements listed above (i.e., clinical, professional, and organizational accountabilities)			
Who will be approached for profession-specific questions that can't be answered in IPS?			
What knowledge and skills, if any, are further needed to undertake this IPS arrangement? (E.g., IPECP competencies, understanding of each other's roles and work contexts)			
What records pertaining to IPS will be kept and who will have access to them?			
When and how will the supervision process and contract (specific to IPS) be reviewed?			
Are there any other considerations?			

(Adapted from [Davys & Beddoe, 2015](#))

Clinical supervision training and research can also benefit from applying the interprofessional lens. Observation and experiential learning, plus learning with and alongside healthcare workers from other professions, have been shown to be highly regarded aspects of clinical supervision training in post-training evaluations ([Ducat et al. 2014](#); [Martin et al. 2017, 2018](#)). Observation and competency assessments are recommended best practice elements of supervision, particularly to enhance the normative aspects ([O'Donovan et al., 2011](#)). Clinical supervision research could focus more on commonalities between professions and how these can be well-utilized and extended to enhance outcomes from supervision for healthcare workers, clients, and organizations. Future research could explore the role of Proctor's model in interprofessional supervision.

Conclusion

Utilizing a framework tested and proven across several individual professions such as the Proctor's tripartite model of clinical supervision, can not only provide a starting point to better understand and engage in profession-specific supervision, but also in the interprofessional supervision context. Effective supervision (be it within or across professions) needs to cater to all three supervision domains namely formative, normative, and restorative, as well as contain direct and reflective aspects. Most often, a combination of interprofessional and profession-specific supervision may be required or desired by healthcare workers. Regardless of the approach, a mind open to professional sharing and learning, and collaborative learning, is necessary to facilitate client-centered care. Those seeking to investigate interprofessional supervision can benefit from understanding IPECP competencies and utilizing frameworks and resources such as the Proctor's model and the proposed interprofessional supervision checklist. In line with best practice, interprofessional supervision needs to be evaluated periodically to ensure it is meeting the needs it was intended to. Healthcare organizations, training providers and researchers can consider applying an interprofessional lens in their clinical supervision practice, training, and research, so that professions can collaborate more to the benefit of clients they serve.

Declaration of interest

The authors do not have any conflicts of interest to declare.

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