In Australia, there is increasing awareness and interest to embed clinical supervision as a core component of professional practice – where dedicated time is regularly taken with a trained clinical supervisor to reflect on interactions and situations arising from the clinical supervisee’s work environment. This may be either through a dyad or small group format, and is distinct from case discussion and review, mentoring, real-time assistance, educational activities, voluntary peer review or any other type of professional development activity that may serve to both develop practitioners and to protect consumers and the general public.

A clinical supervision working agreement or contract is made for the confidential exploration of a professional’s clinical practice, organisational challenges, ethical and professional issues within the boundaries of professional codes of conduct and codes of practice. The focus of clinical supervision is on the supervisee – their agenda, their learning, their choices and their self-determination. The development of trust and the supervisory alliance within the relationship between the supervisor and supervisee/s are central, and contribute to safety and quality of clinical practice as well as the individual’s professional development and wellbeing. Clinical supervision is distinct from statutory supervision for midwives that has existed in the United Kingdom (UK), which places an emphasis on regulating midwifery practice, private or otherwise.

Indeed, clinical supervision is distinct from supervision, the latter of which usually implies a form of regulation and oversight for any profession. As your document Model of Supervision for Privately Practising Midwives, itself, notes in the paragraph on “terminology” (p. 4), “[t]he term supervision often refers to supervision in a practice context such as managerial supervision, professional supervision, or clinically-focussed supervision, and captures both direct and indirect approaches. Supervision in this model provides a much broader scope than this traditional definition and includes mentoring, real-time assistance, educational activities, group case discussion, and voluntary peer review”. Interestingly, this statement does not include the component of “consumer involvement”, which is seen as “essential” in Table 1 (p. 6) and elaborated in Table 2 (p. 8). This is incongruous to the sentiments expressed. Further, the glossary definition of supervision on page 10 repeats this omission: “[s]upervision: in this context includes mentoring, real-time assistance, educational activities, group case discussion, and voluntary peer review”.

The unnamed figure on page 6 does include the component of “consumer”. We suggest that this document is not true to itself, but the real issue from our point of view, is that clinical supervision, which we have been at pains to define, refine and enunciate as a distinct practice in its own right, becomes mixed up with the notion of a regulatory supervision of midwifery practice that is clearly a form of oversight that affords protection for the public. We do not object to that intent, but we do not care for the slippery way that supervision is elaborated in a form that pretends to be concerned with the midwife being at its centre. There is no doubt that what is at the centre of such supervision models is the protection of the public. This worthy intent should be stated clearly. Adding the contemporary notions of
relationships and support for practitioners does not, in any case, change the purposes of regulation and oversight.

The selected model of supervision is clearly one of oversight as in the document’s own words, it “aligns with the Regulatory principles of the National Scheme. These principles have been designed to encourage a responsive, risk-based approach to regulation” (p. 4) in order to protect consumers and the general public. Yet, it refers to clinical supervision (as opposed to supervision) in the following way that we consider is a remarkable feat of legerdemain: “[f]indings from the final PwC report highlighted the importance of having access to a wide range of supports including peer support, mentoring, and clinical supervision. This variety of support is covered in the model as illustrated in the table below” (p. 4). Table 1, as the relevant table, appears on p. 6, and includes the six components of “group case discussion, real-time assistance, educational activities, consumer involvement, mentoring, and voluntary independent peer review” (p. 4).

Including the term, ‘clinical supervision’ here in the first sentence (p. 4) presents conceptual problems as it is then used in the following sentence to suggest that the document is actually referring to clinical supervision when, in fact, it is obviously referring to regulatory, risk-based supervision as a form of professional oversight. This simply does not add up, and for the casual reader, it is at the least, both confusing and misleading, and at worst, deceptive.

Indeed, clinical supervision is not enunciated as a component of the proposed model of supervision anywhere in the document at all. We argue that it should not be included.

ACSA is aware of a growing understanding and interest in clinical supervision among midwives, as one way to support their professional practice, along with a range of other measures. In that context, as a professional body and association that represents and speaks for clinical supervision, we humbly expect that other professional bodies navigate the literature for themselves in order to obtain a clearer understanding of the inherent differences between supervision as regulatory oversight and clinical supervision as a learning and support mechanism.

We are delighted to see that a regulatory body places “the midwife (individual practitioner) at the centre of this model. The components complement each other and make up a model for supervision of midwives” (p. 6). We must point out, however, that this fact, alone – of placing the practitioner at its heart, and which is essential to the practice of clinical supervision, cannot transform regulatory supervision into clinical supervision. This is a conceptual mistake that is often made, quite carelessly, in the burgeoning literature on supervision, yet there remains a 100 years of scholarship on the practice of clinical supervision for it not to be made at all.

Another worrying statement ACSA observes is that within the overarching moderate model of supervision adopted by NMBA, the component of group case discussion is described as a “form of practice group supervision which involves two or more practitioners (minimum two midwives) in a supervision process with or without a lead supervisor” (p. 7). This is a very confused statement in that “practice group supervision” is not readily identified in the literature; in fact, ACSA could not find a single reference. Certainly, there are standard references to group clinical supervision, however, that is not the practice described here.
This begs the question – is this a new practice invented for midwives and PPMs? And where is the evidence base for it. This is a startling development in the worlds of supervisions and clinical supervision. We readily accept the confusion in terminology about these two practices, but to add yet another dimension of an unidentified so-called supervisory practice is simply confusing, and poor scholarship.

Further, although we acknowledge it is a pedantic point, but an important one nevertheless – a “group”, by its nature, must be comprised of a minimum of three people and can include more, whereas two people would comprise a dyad or a couple. This is a grammatical error in this document that should be corrected for purposes of clarity. However, the deeper issue is that the practice of ‘group case discussion’ is simply not a form of clinical supervision. It is what it is – case discussion – either via dyads or groups.

Clinical supervision can occur in a variety of formats such as dyad (or individual), group and peer, and in a range of delivery methods such as Skype, face-to-face, video- or tele-conferencing. While participants may well review their cases, this fact alone does not make it clinical supervision. Case review is rather common within the professions, but case review does not carry the same weight of responsibility that the practice of clinical supervision carries in terms of confidentiality for the open and honest disclosure of the participants involved.

As well as ACSA, many scholars have attempted to clarify the differences between clinical supervision, professional supervision, managerial supervision, preceptoring, Buddying, mentoring and the like, and we include a sample in our references. We believe that, although the professions may not universally agree on a definition of clinical supervision, they do have an understanding that, essentially, these are different practices.

The document asserts that the “components complement each other and make up a model for supervision of midwives” (p. 6). We have noticed an emerging but worrying trend that continues when authors hobble together a variety of practices that often claim a trusting relationship as their essence and to loosely term them all ‘supervision’. As an aside, it is interesting to note that the component, “educational activities” described in this model of supervision does not appear in the unnamed Figure 1. However, one may well wonder why educational activities would be perceived as a component of an overarching supervision framework, as surely educational activities stand on their own merit or belong to a framework of professional development and learning. Education is not supervision.

The overall impression is that although midwives are said to be placed at the centre of this supervision model, in reality, the brand of supervision proposed here is more regulatory in nature, and hence, serves to protect the profession and the public, while also enabling PPMs to obtain indemnity insurance. Simply stating that the “overarching approach is one of supportive supervision where support and guidance is offered through mutual engagement in dialogue about issues of clinical practice” (p. 4) or simply identifying “regulatory and supervisory roles as needing to be distinct from each other” (p. 4) does not make the model any less regulatory. Indeed, as accurately identified by the document’s author, its deliberate alignment with the National Scheme would “encourage a responsive, risk-based approach to regulation” (p. 4), albeit by the “lead entity”, including “professional bodies, employers, governments and individual practitioners”.

Australian Clinical Supervision Association
Proctor argued that clinical supervision as a form of “exciting and creative professional engagement... has been bullied into the background by academic, medical and educational priorities in training and practice” (2008, p. xvi). Similarly, we believe that the unique practice of clinical supervision has been bullied into submission to an overarching framework of supervision with which it is clearly at odds.
References


Bibliography
