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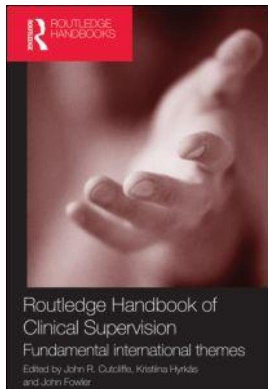

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Fundamental international themes

Edited by John R. Cutcliffe, Kristiina Hyrkäs and John Fowler

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31 Clinical supervision in Canada

Bridging the education-to-practice gap through interprofessional supervision and lateral mentoring: a value added approach to clinical supervision

Nancy Arthur and Shelly Russell-Mayhew

In this chapter, the authors focus on the introduction of interprofessional (IP) supervision as a key direction for advancing clinical supervision within the Canadian context. The authors discuss the advantages and challenges of IP supervision and they offer suggestions for enhancing clinical placements. A new perspective, lateral mentoring, is introduced as a supervision practice, through which trainees benefit from exposure to the perspectives of professionals from multiple disciplines. The authors propose that traditional approaches to clinical supervision may be enhanced by a shift in philosophy and practice towards lateral mentoring.

We believe that this chapter offers a new and important perspective for clinical supervisors and educators in the twenty-first century. The opportunities and benefits of interprofessional supervision are still to be uncovered, but it is possible to assume that this approach will enhance the quality of care, improve interprofessional collaboration and engage patients as active members in their care.

Introduction

Interprofessional collaboration (IPC) is premised on providing the best quality of health care to patients and matching the best expertise of health care professionals to patient needs. In order for IPC to be accepted as the preferred practice or common way that professionals and patients interact with one another, they need to be adequately prepared and supported. IPC calls for a shift in culture regarding how we educate professionals, how professionals interact with one another, and how organizations are structured around professional practice (Herbert 2005).

Although innovative models of interprofessional education and practice have emerged in the literature (e.g. D'Amour and Oandasan 2005), *there has been little attention paid to the ways in which clinical supervision can be leveraged to help professionals acquire interprofessional competencies for "learning with and from other each other to improve collaboration and the quality of care"* (Barr *et al.* 2005: 31). Clinical supervisors are important role models for trainees; supervisors need to be both confident and capable of modeling the value of collaborative practice and provide trainees with learning opportunities on interprofessional teams.

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Context

Within Canada, there are a number of initiatives that have created considerable momentum in the field of interprofessional education and practice, only a few of which are highlighted in this chapter. Initiatives related to collaborative practice have been strongly supported by Health Canada during the previous five years, and are now considered to be an integral aspect of primary care (Herbert 2005). For example, in the landmark report entitled *Building on Values: The Future of Health Care in Canada* (Romanow 2002), Commissioner Roy Romanow emphasized the need for new models of service delivery and new ways of preparing health care professionals. The important relationship between interprofessional education and practice was articulated as follows: "If health care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement" (p. 109).

A major initiative was launched through Health Canada's Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP), aimed at ensuring that health care practitioners have the competencies to practice together through effective collaboration (Herbert 2005). Phase one of this research initiative involved a systematic review of national and international trends in IP education and practice. The results of this review were subsequently published as a special issue of the *Journal of Interprofessional Care* (Hammick 2005). Amidst discussion of relevant terms and concepts, a working definition of IPC was noted as:

> A way of health care professionals working together and with their patients. It involves the continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient … It enhances patient- and family-centered goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines, and fosters respect for disciplinary contributions of all professionals.
>
> (Herbert 2005: 2)

Phase two of the initiative focused on the advancement of knowledge through multi-year IECPCP learning projects to advance research and practice within the Canadian context.

Another example of initiatives in Canada demonstrates the importance of collaboration between professional associations. In 2006, the Enhancing Inter-disciplinary Collaboration in Primary Health Care (EICP) Initiative, a coalition of ten professional associations (e.g., Canadian Medical Association, Canadian Psychological Association, Canadian Nursing Association), released their *Principles and Framework for Inter-disciplinary Collaboration in Primary Health Care* (EICP 2006).

A central message emerging from these initiatives is that the future delivery of health care requires professionals to work together effectively. Health care policy that addresses IPC is being integrated into workforce planning and the operations of many organizations. However, there are wide variations in the degree to which practice sites are ready to engage in IPC. In turn, there appear to be varying levels

of readiness in terms of professional attitudes that support collaborative practice, knowledge about best of practices, and skills to enact successful collaboration. The field of interprofessionality has made tremendous strides during the past decade in emphasizing the benefits and barriers for professional practice. Along with advances in conceptualization and models, there is emerging evidence to show the benefits of IPC (Barrett *et al.* 2007). *It is timely to consider the ways in which clinical supervision can be enhanced through incorporating fundamental principles and practices of IPC.*

Reasons for interprofessional collaboration

There are a number of reasons commonly cited to support an increased emphasis on IPC related to patient care, staff satisfaction, workforce optimization, and health care resources (Herbert 2005). First and foremost, the complexity of patient issues means that a variety of professional expertise is often required to address multilayered care. Correspondingly, a coordinated effort is needed to involve multiple professionals in service planning and delivery. Professionals may feel less overwhelmed with the complexity of patient needs if they can tap into a system of shared expertise. Professionals may also benefit if case planning allows them to use their best specialist skills. Therefore, it is proposed that both patients and professionals benefit from the availability of appropriate consultation, referral, and appropriate service resources. Coordinated care often requires bringing together available resources within or between service agencies. However, it is important to go beyond bringing people together; they need to be trained to work on professional teams and with competencies to maximize the effectiveness of collaborative care.

Financial issues and operating costs have prompted a spotlight on workforce optimization. The increasing costs of health care require innovative practices that optimize the roles and functions of professionals who provide services. The idea is to have the best person with the best skills providing the best services, and avoid duplication and "wasteful" use of professional expertise. A related issue is the predicted shortage of health care professionals, which has prompted examination of workforce utilization and scope of practice. Calls to reform health care have emphasized the necessity of IPC as a leading edge in future health care planning and implementation (Romanow 2002).

The call for a changing culture in health care must be matched with corresponding changes in the ways that we prepare trainees. It is recognized that health care practitioners do not work in isolation, but must be prepared to work on health care teams. It is increasingly common for health care staff to consult with, refer to, and seek resources for patients from professionals from various disciplines. Given the emphasis on team-based approaches to service provision, professional education curricula need to support the acquisition of competencies for IPC (Suter *et al.* 2009). However, there has been limited discussion in the literature about clinical supervision and ways that principles of IPC could be integrated into supervisory practices.

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Infusing interprofessional collaboration into clinical supervision

Supervision has been defined as "a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex situations" (Bailey 2004: 267). Supervision is seen as fundamental to the process of professionalization, and each profession has developed its own supervision history and literature (Clouder and Sellars 2004). One factor that appears to cut across professions is the importance of learning from practice. Yet, there appears to be wide variation in approaches, and little accountability regarding how supervision practices prepare trainees for working both within and across professional disciplines.

The key features of IP supervision are: (a) an interaction between at least two people; (b) one person is attempting to support the other in becoming better at helping people; (c) the process is about a relationship within which education, support and quality control can happen; and (d) there are two or more professional groups represented in the interaction (Davies *et al.* 2004). The importance of incorporating multiple perspectives is a common theme in the literature on IP collaboration (Peacock *et al.* 2001). A parallel process occurs at the level of IP supervision. For example, the roles we need to consider in supervision are, at minimum, the supervisee, the supervisor, and the patient(s) and perhaps also other team members, family members and academics. Intuitively, it makes sense that IP supervision might work because knowledge in real life settings is not applied in a "take turns" fashion but rather in an integrated holistic way.

There are many benefits associated with IP supervision. *The essence is that IP supervision provides opportunity for multiple perspectives and a wider knowledge base. Increased creativity, critical thinking, and decreased complacency have been theorized as advantages to IP supervision* (Bailey 2004). It has also been proposed that there are enhanced contributions to the transfer of learning from training to practice (Bailey 2004).

Although the focus of the discussion has been on the benefits of preparing professionals for IP collaboration, the potential benefits for patients need to be considered. To recap, one of the primary purposes of interprofessional collaboration is to improve patient-centered practice (D'Amour and Oandasan 2005). This requires professionals to look carefully at what patients need and ways to include them in determining the direction of their care. Patients are increasingly being called upon to be active members in managing their care, but their roles on interprofessional teams are not well defined. The extent to which patients define themselves as active members of IP teams or passive recipients of care varies considerably according to patient expertise and service provider practices (Pyle and Arthur 2009). As we look towards IPC as a means of improving health care, professionals will need to be informed about ways to empower their patients and relate to them as active decision makers. However, there appears to be variability in the extent to which professionals are willing and able to amend their traditional position of an expert, and share decision-making power with patients. In turn, *approaches to clinical supervision will need to shift from an emphasis on delivery of care* to *patients towards collaborative care with patients, and consider trainees as active collaborators in the learning process.*

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Barriers to interprofessional supervision

Along with many of the positive assets associated with interprofessional collaboration, a number of common barriers have been identified related to professional knowledge and scope of practice, role clarity, power and status, and the rigidity of professional cultures (e.g. Baxter and Brumfitt 2008; Hall 2005; Kvarström 2008). In turn, a number of contentious issues appear as barriers for IP supervision. For example, different experiences and interpretations of what supervision means within each professional body sets up a system where protecting the autonomous nature of the home profession is commonplace (Hyrkäs and Appelqvist-Schmidlechner 2003; Larkin and Callaghan 2005). Professional codes of practice have traditionally required supervision within the individual profession itself and each professional brings a history and practice experience about supervision (Bailey 2004; Emerson 2004; Townend 2005). As such, a number of difficulties related to supervision in an IP context emerge as locations for learning about IP collaboration.

First, there are practical and logistical issues to address, such as time for case consultation and how to coordinate schedules so that professionals from various disciplines can come together for supervision sessions. These organizational constraints should not be viewed lightly or their importance minimized; our experience in attempting to shift traditionally uniprofessional education to shared classrooms and instructional time has proven that this is often a monumental task, requiring a high degree of commitment between academic departments and practice sites.

Second, there are a number of terms used between professions to describe what might traditionally have been considered the supervisor, including mentor, facilitator, clinical supervisor, practice teacher, fieldwork educator, peer reviewer, tutor, preceptor, and field/site supervisor. It should not be assumed that these terms can be used interchangeably, as the roles and functions may differ and the quality of supervision may suffer if key elements are lost (Yonge *et al.* 2007).

Emerson (2004) proposes that "placement educator" is a neutral term that could transcend the different professions. However, this issue is more than about semantics, it is important to consider what is meant by supervision, and how the functions, goals, and processes in common might be negotiated. Bailey (2004) proposes that "clinical supervision" be called "work-based supervision" because it is more inclusive of a number of professions. The emphasis on work-based supervision also acknowledges the emphasis on socialization to the workplace and preparing trainees for bridging education with workplace practices.

Third, the issue of language is connected to issues of professional identity and power between professional groups. The willingness to negotiate a commonly understood term for supervision might be an indication of the willingness to transcend traditional domains of practice. The bottom line is that power issues intrude on the possibility of IP supervision. Underlying issues of professional stereotypes and professional status need to be addressed, in order for IP supervision to be accepted as legitimate practice.

Fourth, ethical issues seem to pervade discussions about IP supervision, although the nature of such concerns is rarely specified. A notable exception is a study by Wall and Austin (2008) in which the dynamics of negotiating ethical practice in health care teams is detailed. The question of whose code of ethics prevails is posed

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as a barrier and traditional reporting relationships may lead some professionals to claim more authority and more liability than others. New ways of working that involve sharing of power and control can lead to strong emotional reactions. It is possible that anxiety and fear may be heightened when "other" professional groups are involved in supervision, due to concerns about revealing weaknesses to other professions (Hyrkäs and Appelqvist-Schmidlechner 2003; Townend 2005). Yet, these very concerns underscore the importance of supportive supervision practices that address such dynamics in the workplace.

Fifth, one of most contentious barriers is how professional associations recognize supervision hours for trainees who are attempting to meet requirements for licensure or registration in their own profession. It is one thing to have conceptual agreement that working together on IP teams is conducive for learning. However, until professional associations begin to recognize and legitimize this form of training, IP supervision will not likely be viewed by professionals or trainees as a necessary part of professional education.

We are heartened by the fact that discussion of these barriers has surfaced in the literature to encourage open dialogue about the structures and functions of interprofessional education and practice. Such discussions may serve the dual purpose of addressing traditional barriers, and also focusing on issues from which tremendous learning about IPC may occur (Kvarnström 2008).

Supporting interprofessional supervision

Given the discussion of the advantages of pursuing IP supervision and the existing barriers to doing so, we offer a key question to further the debate: What will it take to support IP supervision? To recap, there are encouraging signs that professional groups are more often working together through a commitment to patient-centered collaborative practice as a best practice in the delivery of health care services. Concurrently, we need to prepare health care professionals for the realities of professional practice in which they will need to perform as a member of the larger care team.

What becomes obvious is the need to prepare trainees to make the transition from a trainee to a competent and confident member of an interprofessional team. One of the key ways of addressing the gap between education and practice is through IP supervision. In order to enhance IP supervision practices, more research is required which addresses what makes these experiences effective and efficient for all involved, including supervisors, supervisees, and patients. For example, research has examined trainees' perceptions of the benefits of supervision through preceptorship in comparison to supervision provided through a collaborative learning unit in which trainees had access to a number of mentors within the nursing profession (Callaghan *et al.* 2009). Research could be extended to consider trainees' experiences with IP supervision.

One particularly successful endeavor in IP supervision involved different professionals all trained in cognitive behavioral therapy (CBT) (Townend 2005). Although each CBT practitioner may have been from different and diverse professions, the fact that they all had training in this particular approach to service delivery facilitated the IP supervision of the team. Pragmatically, common documentation systems (Larkin and Callagan 2005) such as the way patient files are managed and main-

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tained, joint supervision policies (Larkin and Callaghan 2005) such as the required number of individual versus group supervision hours, and a developmental approach to improving practice (Bailey 2004) have also been shown to facilitate successful IP supervision experiences.

Research has articulated competencies that may be addressed through supervision to enhance trainees' capacities for collaborative practice. In particular, role clarity and effective communication are highlighted (Suter *et al.* 2009). Research has also informed the development of frameworks in which core domains of interprofessional practice are defined with requisite competencies (e.g., Wood *et al.* 2009). In Canada, a national interprofessional competency framework (Canadian Interprofessional Health Collaborative 2010) has been developed. This framework is intended to guide the interprofessional education curriculum, and the competencies can be used to set standards for interprofessional practice. It is also a beneficial document to chart the course for IP supervision. Supervisors and trainees could use the competencies as a foundation from which to direct supervision planning, trainee learning activities, and debriefing of practice experiences.

Some key debates in the field remain. For example, when is the optimal time to introduce trainees to interprofessional practice: alongside the development of their professional identity or post-licensure? We would argue that exposing trainees early in their professional education programs has tremendous benefits for learning about their own disciplines and the disciplines of other health professionals. Part of the challenge, however, is creating learning opportunities for collaborative practice. The practicum component of professional education is a key time from which to foster IP supervision. However, it is of concern that it is left up to the individual interests and expertise of faculty and site supervisors to determine learning objectives and practice activities. Integrating interprofessional competencies into professional education, and particularly practicum training, would be a starting point. This could open the door for a coordinated approach with both faculty and site supervisors about how opportunities for interprofessional learning could be integrated into practicum experiences.

A related implication is that faculty and site supervisors need to be adequately prepared to design and deliver IP supervision initiatives. The extent to which supervisors are chosen for their supervisory versus clinical experience remains a concern. It should not be assumed that an experienced clinician has the requisite skills for supervision. Literature suggests that the success of supervision is highly dependent on the skills and qualities of the supervisor (Hyrkäs and Appelqvist-Schmidlechner 2003). Recent research has suggested that there are notable gaps in both the perceived competencies of supervisors for engaging in clinical supervision and their confidence for doing so (Heale *et al.* 2009). *It is evident that in order to promote effective IP supervision, the preparation of both supervisors and trainees needs to be taken into account.* In a previous publication (Arthur and Russell-Mayhew in press) we described a workshop designed for site supervisors in the fields of psychology, nursing, and social work to come together to learn more about interprofessional practice in general, and about ways to specifically foster IP supervision.

Although there are examples of research that address the perspectives of supervisors and trainees (Bailey 2004; Hyrkäs and Appelqvist-Schmidlechner 2003; Hyrkäs *et al.* 2002), the links between IP supervision and patient outcomes have not been researched. Again, we need to keep in mind that the purpose of IP supervision is

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about more than fostering the education of future practitioners; it is about providing quality care. *The extent to which IP supervision contributes to positive patient outcomes requires future examination through research.*

Recasting supervision as interprofessional mentorship

The discussion in the previous section outlines some of the benefits and challenges for advancing IP supervision. One of the most promising directions is the opportunity for supervisory practices to be revised, based on current knowledge about IPC. If we accept the notion that trainees may be better prepared for their future practice roles through exposure to the practices of professionals from multiple disciplines, then that idea should translate into future directions in supervision. It has been proposed that traditional supervision models could be expanded to an IP mentorship approach, in which trainees would have opportunities to "learn with and from staff and trainees from other disciplines" (Lait *et al.* 2010: 1). The concept of lateral mentoring is based on the premise of shared expertise that could be used to guide supervisory practices for clinical and work-based placements. *The key idea is that supervision would be enhanced by moving away from reliance on the expertise of only one supervisor, to incorporating the expertise of several practice site mentors, from various disciplines.* Trainees could still be assigned a primary supervisor or preceptor in their professional discipline in order to preserve the key teaching and learning functions of that role (Yonge *et al.* 2007). *However, trainees would also have the advantage of learning from a team of professionals assigned to their supervision.*

Preliminary research has identified a number of potential advantages to lateral mentoring (Lait *et al.* 2008). First, the main advantage of lateral mentoring is that trainees have the opportunity to learn from a range of professionals. That means they are exposed to multiple disciplinary perspectives and multiple approaches to supervision. Second, lateral mentoring supports trainees to find out areas of commonality and effective team practices (Mullarkey and Playle 2001). Third, at the same time, through recognizing differences, trainees acquire appreciation for the unique contributions to be made by their own profession and by members of other professional groups. Fourth, lateral mentoring activities can be used to support trainees to gain a multitude of competencies (e.g. problem-solving, teamwork, professional behavior) that are not profession-specific. Mentors do not have to be from the same professional discipline in order to enhance trainees' competency development. Fifth, a point that deserves to be reiterated is the necessity of preparing trainees for the realities of practice they will face in the workforce. Lateral mentoring provides early exposure to working with other professionals and helps trainees to develop competencies that builds their capacity for future IPC. To summarize, lateral mentoring involves enhancing trainees' understandings about their own profession, other professionals, and how to work together collaboratively for future practice.

A final point is warranted about the implementation of lateral mentoring. These suggestions can be implemented without major changes to the educational curriculum, but through leveraging available opportunities in practice settings (Lait *et al.* 2008). It may be necessary to address some of the attitudinal barriers that continue to set limits on professionals working together. However, willingness to share expertise, including supervisory expertise, has been shown to have major benefits for trainees from a wide variety of academic disciplines (Lait *et al.* 2008). If resources

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are coordinated in more effective ways, trainees and professionals may benefit from the learning that occurs through interactions with one another. Ultimately, this should translate to trainees developing competencies to enhance patient care in ways that are not possible through supervision from only one discipline. *In order to shift the emphasis from hierarchical models of supervision, lateral mentoring offers the advantage of incorporating many of the foundational premises of IPC that exemplify best of practices in health care.*

Conclusion

The field of interprofessional education and practice has emerged as a key direction for the future of health care. IPC is based on the premise of improving patient care through bringing together the best people to provide the best care. However, the call for IPC must be matched with curriculum reform, including approaches to supervision. This chapter has outlined several benefits of adopting IP supervision as a value-added model for enhancing the competency development of trainees. Based on the notion of learning with and from each other, IP supervision affords trainees the opportunity to be exposed to the practices of other professionals. We would encourage professionals in practice sites to become more than contacts for trainees, and take on the role of mentors in fostering their professional growth and development. Lateral mentoring provides unprecedented opportunities for trainees to experience the roles and responsibilities of their own profession in relation to other professions they will inevitably work with in the future. If we consider work-based supervision as a bridge between education and practice, trainees would benefit from having a number of mentors to help them cross that bridge. Learning from the expertise of multiple professionals provides a foundation of practice from which trainees can develop their sense of professional identity and foster interprofessional practice competencies. Advancing clinical supervision approaches to incorporate lateral mentoring will support the preparation of professionals who are ready, willing, and able to engage effectively in IPC.

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