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Additional barriers to clinical supervision for allied health professionals working in regional and remote settings

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Dawson *et al*.[1] examine the importance and relevance of clinical supervision (CS) for regional allied health professionals (AHPs) from a supervisor's perspective, following their previous study examining CS from a supervisee's perspective.[2] Both studies examine potential barriers to and outcomes of CS and factors affecting its success in promoting and supporting professional learning and capacity building in a regional setting.[1] As an AHP working in regional and remote settings, I wish to raise some additional barriers to CS.

Given the relative shortages of some AHPs in Australia, the Northern Territory (NT) has traditionally been a place where many health services are spread thin on the ground. Gaps in services have often been filled by contractors, engaged on a fly-in, fly-out basis. The combination of fly-in, fly-out workers and years of short-term funding cycles has led to a fragmented outreach AHP workforce, largely left to their clinical roles with few options for any form of supervision. Clinicians engaged in this work range in experience from new graduates to very experienced.

Reviews of present literature on CS describe CS for clinicians who are working as part of a team and in the earlier stages of their career,[2] and those who are in managerial positions.[3] The benefits of CS are widely recognised and range from improvements in patient care to reduced levels of clinician burnout.[1,2,4]

In discussing the responses of CS on supervisors, Dawson *et al*. raise the point that there is confusion regarding the delineation between CS and other forms of supervision, such as line management and performance management.[1] Several widely recognised frameworks for CS exist, including the Proctor 3 part model[1] and Herons 6 category intervention;[5] however, there is little in the literature to suggest whether or at what point in one's career CS requirements change.

Presumably with years of experience one's clinical skills develop and are maintained to the point where they no longer require regular supervision; however, in their 2005 study addressing CS and burnout, Edwards *et al*. discuss the potential benefits of CS in addressing perceived workplaces stressors before clinicians 'burn out[4]'. Surely a clinician could be at risk of burnout at any point within their career and, for this reason, should CS be a priority area of supervision throughout one's career?

Dawson *et al*.[1] comment that CS is considered difficult if there are interpersonal relationships between the supervisor and supervisee, particularly when difficult issues require discussion (e.g. discipline). This will more likely be an issue in small regional departments where there tend to be fewer candidates to fulfil the supervisory role. In remote areas, this effect is magnified and the pool of suitable supervisor candidates is dramatically smaller.

There are many and varied reasons to implement a comprehensive permanent AHP workforce in the NT, opportunities for appropriate CS and support not least among them. As evidenced by the article of Dawson *et al*.,[1] doing so may assist in delivering higher-quality services and preserving clinicians engaged in a very specific avenue of service delivery.

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