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Osteopathy Board of Australia (OBA)
Draft Guidelines for Supervision of Osteopaths

Submission by the
Australian Osteopathic Association
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The Australian Osteopathic Association (AOA) appreciates this opportunity to comment on the Osteopathy Board of Australia (OBA) Draft Guidelines for Supervision of Osteopaths. We note with some concern the high number of consultations released by the OBA in December with a closing date in January or early February and the impact this may have on effective or inclusive consultation.

The Australian Osteopathic Association

The Australian Osteopathic Association (AOA) is the national professional body representing over 85% of osteopaths across Australia. This gives us a unique voice for representing the profession and lobbying to ensure high industry standards are established or maintained.

Our core work is liaising with state and federal governments, regulatory or other statutory bodies and key stakeholders, such as Universities. As such we always welcome opportunities for input or collaboration, such as this.

This Submission

It generally acknowledged that if guidelines are to be effective and enforceable they must be clearly understood and directly applicable to those being regulated and not be open to varied individual interpretation and/or application. While overall, **we welcome a clinical supervision guideline; however, the AOA has significant concerns regarding the proposed model and question if this will contribute anything to increasing public safety or safe osteopathic practice**.

As a general observation it would appear that this simple model of supervision may be appropriate for those employed within of large hospital or healthcare setting with a hierarchy and management system. When being applied to the context of common, small osteopathic private practices with standard associate / principal relationships, the guidelines in their current form are highly problematic if not questionable.

Under 'Scope' in the first paragraph, dot points 2 and 4 seem to refer to the same thing.

Background

As previously stated, the AOA is keen to see and foster a more constructive and consultative partnerships in guideline development into the future. We are further saddened that such open, consultative process opportunities, as used with the Informed Consent Guidelines have been ignored in other OBA guideline development.

The AOA strongly supports the development of a pool of appropriately skilled and trained practitioners who are willing and able to provide appropriate skilled supervision. The fact that under the proposed guidelines virtually any osteopath with general registration can

supervise is of concern as a working knowledge of the Capabilities for Osteopathic Practice is required, along with the ability to undertake assessments and encourage evidence-informed practice.

Capabilities Framework

The policy does not reference a competency or capabilities framework. An individual osteopath working under a supervision order would have no objective frame of reference for what constituted competence in practice or which areas of the competency or capabilities framework are not currently up to date. How will the OBA ensure consistency in standards and what is deemed acceptable in the absence of such a framework? How would the OBA defend itself against allegations of biases where individual supervisors are accused of imposing personal approaches to practice as being the required standards? This clearly leaves the supervisor, the supervisees and the patient vulnerable. We questions if this will meet the test of public protection.

The NSW Registration Board previously endorsed the UTS Capabilities for Osteopathic Practice and the AOA requests why the OBA has not adopted the capabilities framework? The AOA was a stakeholder in their development and actively participated in the research project that produced them. These are broad based and were developed using extensive consultation processes with the Australian osteopathic profession. One would assume these have been enhanced further by the research to develop performance indicators carried out by Victoria University and funded by the OBA.

Clinical supervision is a trained skillset

Clinical supervision and mentoring skills are required to competently (and safely) carryout a supervisory role. It is a concern that these guidelines enable anyone to be eligible to supervise another healthcare professional in the absence of training program to equip the supervisor with the necessary knowledge, skills and attitudes. **Merely being in practice for 5 years is not an indication that the individual registrants will have supervisory skills**. In the absence of a capabilities framework this clearly increases further the risk that a supervisor's judgment could lead to allegations that personal / subjective determinations of what constitutes competence in practice are being imposed.

From this guideline it appears the only real requirement of a supervisor is that they have general registration and 5 years' experience. This appears to be quite open, vague and requires further development and criteria to be clearly defines.

The AOA requests that the assessment methodologies developed for the ANZOC work based portfolio competence assessment is used as the basis of supervisory process. The AOA participated in the development of the ANZOC overseas assessment process and understand that it uses current best practice in the assessment of clinical competence and utilized some of Australia's leading academic experts.

We understand that the portfolio assessment has been successfully delivered by ANZOC over the last 18 months and that clinical educators from all 3 Australian universities have been trained up in the use of the assessments. These could form the core of the required pool of supervisors and be supplemented over time by developing a suitable training program. We would welcome the opportunity to work with the OBA / ANZOC and the Osteopathic clinical educators to ensure that this occurred.

Under 'Principals' in Part 5 the term 'properly supervise' needs to be better defined. As an absolute minimum) to educate and warn the supervisor of what is expected of them by the OBA to meet such a standard. This guideline lacks such definition or clarity.

On a practical level regarding requirements and responsibilities of supervisors:

- Who actually identifies the supervisor?
- Is it from a pool of approved supervisors?
- Is there any payment of supervisors?
- Some of the tasks and the time required is quite onerous and require time away from treating patients or other activities, what benefit does this offer the supervisor
- Under part 9, it may be worth clarifying the 'delegation of tasks'
- There is no direct mention of the supervisor having to perform any type of assessment on the supervisee, can this requirement be clarified?
- Responsibilities of supervisees, at part 4, what types of assessments are they participating in?
- Will supervisors be trained in undertaking and understanding assessment methodologies?
- Responsibilities of supervisees, at part 9, it asks the supervisee to contact AHPRA. It may be better that there is a designated contact at AHPRA that is put into the Supervision Plan. That way, the supervisee knows who to contact should there be any issues, particularly if they have to cease practice due to a lack of supervisor
- Will supervisors be able to a contact staff at AHPRA for information and advice or will alternative support arrangement be in place?
- Will AHPRA provide counseling and support for supervisors?

Levels of supervision

At level 1, supervision is performed by the Clinical Educators at universities and where they will assume responsibility for patient care and indemnity risks. **Can the OBA outline if they have engaged and consulted with universities to ensure such an option is available and what fees are involved?**

Will the registrant requiring supervision be required to cover any such costs?

There is a substantial onus on the supervisor under level 1. With the requirement to be physically present at the workplace but not have a relationship with the supervisee; it is really only the universities or a paid, skilled and qualified supervisor that will be able to provide this level of supervision.

At level 2 under specifications, 'majority of time' needs to be defined in some way. This lack of clarity and specificity is a real weakness in the guideline.

Conflict of interest and a lack of transparency

99% of osteopaths work within private practice either as business owners, or associates in contractor or employee arrangements. **Therefore we are concerned that having a supervisor who works in the same practice is an unacceptable conflict of interest and lacking in transparency.** The supervisor will have a pecuniary interest in the supervisee successfully completing their program and this weakens the protection of the public. Generally the AOA considers that only university teaching clinics or a *trained* and experienced supervisor could undertake the level of supervision required for levels 1 & 2 be delivered.

Furthermore, we have concerns that such supervisory situations will have a very high probability of being attached to income potential for either the Principle or associate or both and that leaves either party open to abuse, undue coercion or intimidation during the supervisory processes.

Supervision for recency of practice / return to practice

In the interests of transparency the AOA feels that the OBA should publically outline a recency of practice schema that details the standard return to practice requirements and principles based on time out of practice, for example:

Years out of Practice	Competencies identified to Achieve	Assessment and Supervision Requirements
1-3	A, F , G	Supervision for 3 months Undertake CPD on X, Y and Z etc
3-5	A, F, G, J,Z, T, M	
5-7 etc	A, B, C, F , H , I , L, Z etc	

This schema should clearly outline the minimum requirements for any returning registrant. This will also ensure that the prerogative of public protection is being seen to be met.

Particularly where osteopaths have been out of practice for 5 years or more it is likely that only within the environment of a university teaching facility would the level of support, education and clinical supervisory skill be found to effectively deliver return to practice supervision. Indeed where osteopaths have not been practising for extended periods of time a detailed assessment of their competence would be required prior to establish their learning needs. It is hard to see how the context of private practice could provide such an environment.

Supervision after conduct matters

This guideline fails to address how a suitably qualified and skilled supervisor will be matched to a registrant when supervision is required after a conduct complaint or when conditions are imposed. In such situations a supervisor will need to have extensive skills to improve the identified area lacking in knowledge, conduct or skill in the registrant needing supervision. It is unclear how such supervisors will be accessed as suitable or found. Relying on any osteopath with 5 years of experience (with no skills assessment or training) is clearly in contradiction to almost every education philosophy and makes a mockery of the intent to protect the public through such an arrangement.

Professional Indemnity Insurance

The AOA has further concerns regarding the professional indemnity insurance arrangements. **Under part 5, of Principles there seems to be a substantial onus placed on the supervisor and this may have PI insurance implications.** It is unclear if we may need to warn our members of these risks if becoming supervisors.

Will the OBA indemnify supervisors acting on their behalf in relation to conduct or recency of practice matters? If not this risk must be explicitly explained to all supervisors.

Calculation of the actuarial risk and the additional premium for supervisors would be difficult and insurance companies may be reluctant to offer cover, particularly as the proposed scheme has not capabilities framework or supervisors training program. It would be unacceptable to the AOA to increase the general premium paid by all members and it is likely that standard cover would not provide adequate protection for supervisors. Ultimately a supervisor may be vicariously liable for any injury as the result of treatment by the supervisee.

As such this guidelines should be clear around the needs to ensure that the supervisor has appropriate indemnity insurance to cover such supervisory arrangements, if not require proof of such cover prior to being nominated as a supervisor. This may be further complicated if the insurer requires proof of skills, training and experience in supervision to provide cover.

Payment of Supervisors

Clearly the task of supervision is onerous and would not be taken on with recompense. The AOA is concerned about the costs of the supervision process being passed on to the general registrants. The costs of return to practice / recency of practice ought not to be borne by the general registrants but the individual. We would welcome details on how these costs can be identified and passed on to the individual supervisee.