CNSSA POSITION STATEMENT

In reaction to various complaints received by fellow professionals, CNSSA has decided to investigate and clarify many aspects of supervision and delegation.

DEFINITIONS OF SUPERVISION

There are numerous definitions of supervision, many of them not sufficiently thorough, or broadly accepted, for us as practitioners in (and stewards of) clinical neurophysiology. Before looking at classifications, let us first state a good definition for the foundation of this Statement Document: (www.businessdictionary.com/definition/supervising.html):

> *"Supervision is defined as the monitoring and regulating of processes, delegated activities, responsibilities, and tasks."*

Monitoring and regulating, together, means this is a special relationship of a trainee or junior practitioner, requiring assistance to conform to profession-decided competencies; and a supervisor, taking ultimate responsibility both for the delegated process and the growth of the supervisee. Monitoring, by any means, creates this relationship. But regulating also means there is an enhancing influence from above on the supervisee.

FORMS OF SUPERVISION

This list below was obtained from an American Dental Hygienist document, but apparently these are all well-known in medical circles in that country.

D Direct Supervision Levels; dentist needs to be present
P Personal Supervision: Dentist needs to authorize, be present and check prior to patient dismissal
ID Indirect Supervision Levels; dentist must authorize procedure and be in the dental office while the procedure is performec
G General Supervision Levels; dentist needs to authorize prior to services, but need not be present
CP Collaborative Practice: RDH may practice without supervision, pursuant to a collaborative agreement between the RDH and a licensed dentist
A Direct Access Supervision Levels; hygienists can provide services as s/he determines appropriate without specific authorization

It is clear that even we old, independent practitioners / private practitioners may fit some of our competencies along various levels of this list. Lifelong learning is mandated by the HPCSA, and we regularly perform CPD activities to maintain and improve our knowledge and skills. That is the supervisory influence of the Medical Profession on ours. Everybody has several levels of personal skills (competencies), not only one. This set for each individual is called their personal scope of practice. This is defined in terms of the supervisory relationship being intact and recognised appropriately.

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GCT's practice, according to above, for those competencies prescribed by the HPCSA (the Profession's scope of practice), falls into Collaborative Practice. But, what about neurofeedback, which is commonly performed by teachers and psychologists with minimal neurophysiology training? Or TENS? Certainly, that skill belongs for us in the Direct Access category! And appropriate, responsible referral within Clinical Neurophysiology would also fall within this category.

From an HR point-of view, I obtained this detailed version of General Supervision:

General Supervision: The supervisor provides continuing or individual assignments by indicating generally what is to be done, limitations, quality and quantity expected, deadlines and priorities. Additional, specific instructions are given for new, difficult, or unusual assignments. The employee uses initiative in carrying out recurring assignments. The supervisor assures that the work is technically accurate and in compliance with instructions or established procedures.

https://www.alaska.edu/classification/faqs/levels-of-supervision/

Registered EEG Technicians falls for EEG production into the General Supervision level, and so should 4th year neurophysiology students, or the Technical Universities are causing occupational drift openly, something South Africa's oldies accuse them of for decades.

Direct Supervision is the first contact type, and for EEG production lasts only about 6 to 8 recordings, on average, for the average, enthusiastic student. This has not changed in decades, and since neither the technique, nor the basic knowledge required to prep and run an EEG have changed much, it is not expected to ever change. If you keep looking over their shoulders, they will never learn to produce EEGs responsibly and the supervisor will never be able to add that skill to a competency evaluation. The registration will certainly not do that. It is an irresponsible requirement form want-to-be-supervisors without the necessary skills for such oversight.

As the purpose of training is to prepare students for either levels Generalised Supervision or Collaborative Practice, it can be expected for them to gradually raise through the ranks during the training period. Only truly complex cases, and medico-legal cases are treated differently, traditionally, as they would require certification to prove competence to the interested parties.

But, as clinical supervisors, we have responsibilities towards both patients (the public) and our Profession. We, however, need to be realistic with regard to both the Profession's perceptions of the requirements or detail (the meaning of the terms), and that of the public, through experts in employment relations and clinical education.

A brilliant working document for the profession to explain independently to outsiders, such as the medical aids, training institutions, and governing bodies, is the website of the American AAPC. This is the American body that is on the Professions' side and advising the business relationships of American practitioners.

> ***The Americans have an association, the AAPC, which train their coders and auditors. I do not believe we can afford the American model, but still, the South African system is increasingly based upon theirs.***
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> *General supervision means the service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and maintain the necessary equipment and supplies, is the physician's continuing responsibility.*
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> https://www.aapc.com/blog/31674-let-me-be-direct-about-physician-supervision-requirements/

IN SUMMARY

Taking all above together the following can be deduced:

- Supervision is a delegation from a senior who retain the ultimate responsibility for the personal scope of the supervisee. No medical aid or training institution can carry that responsibility, or regulate it professionally.
- That scope may include both tasks that can be performed completely independently, as well as more complex tasks requiring physical assistance, or regulation by many different appropriate means available to us modern practitioners.
- Along the range of complexity, some tasks can be sufficiently supervised via electronic means and Standard Operating Procedures, without creating risks for patients, the public, or the Profession.
- Independent institutions, or even other practitioners not familiar with the personal scopes of practice of supervisees, behave unethically by insisting on alternative modes of practice without specific reasons for doing so. HPCSA Generic Ethical Rules 2007:

> *12. Professional reputation of colleagues*
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> *12. A practitioner shall not cast reflections on the probity, professional reputation or skill of another person registered under the Act or any other Health Act.*

- It is advisable that supervisors keep record of competencies, especially the outcomes of specific Competency Based Tests, during training and ordinary

practice relationships, to support their decisions regarding their supervision of students and junior staff, independently.

- It is advisable that the HPCSA registers only candidates fully competent in the Professional Scope in any register. For example: The EEG Technician Professional Scope requires practitioners to be able to perform EEG recordings “without direct supervision”, but then registers some practitioners under “supervisory practice only”. Nobody knows the meaning of that, and it looks like occupational drift or shirking of responsibilities to fail poor candidates at examinations. If someone could record EEGs in the 1970’s without direct supervision, it would be unprofessional to require that person to now only work under direct supervision, or any form of higher supervision, without reason to change the particular registration.
- EEG Technicians work under general supervision, meaning that they know the SOPs for most EEGs, and have been proven to be able to produce recordings reliably if those are read by a competent Clinical Technologist or Medical Practitioner (ordinarily only neuroscientists, and increasingly only under those with proven competencies in the practical aspects of complex EEG recordings, too). Every EEG produced is also seen and interpreted by the supervisor, and regular feedback on production technique is given.
- 4th year Clinical Technology students are expected by the professions to be at least on the same level, at least with regard to EEG production, as EEG Technicians.
- 3rd year Clinical Technology students and EEG Technician students study and practice to reach the competency for practice without direct supervision, before their final examinations, and may reach that long before their registration. This put a special responsibility on the training supervisor to be able to prove competencies in writing before registration. When this can be done, nobody else should be expecting any such candidate to receive further direct supervision for that skill, according to the HPCSA Ethical Rules, par 12.
- Wasting money by requiring extra persons to be present during EEG production is not in public interest, nor in that of the Profession. Such requirements must be accompanied by specific reasons that can be addressed and remedied in the relationship of the supervisor with the specific practitioner. If a supervisor cannot resolve such an issue, it becomes Professional interest to do it in collaboration with the rest of the professions, through this Professional Society or the Profession al Board, for example. Legally, their word is final,