Supervision

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Supervision is a key feature of professional development in a wide range of professions. The Royal College of Psychiatrists, in its 'Statement on approval of training schemes for basic specialist training for the MRCPsych' (available on request from the Postgraduate Educational Services Department of the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG) dictates that each basic specialist trainee should have a "protected hour per week" with his or her educational supervisor. This time should belong "exclusively" to the trainee and be "for the benefit of the trainee". The *Higher Specialist Training Handbook* (Royal College of Psychiatrists, 1998) also emphasises the central importance of supervision as part of higher training for specialist registrars. Training consultants are expected to be "readily available" to trainees, and to provide a "regular, weekly, timetabled supervision session". Supervision is obviously perceived by those responsible for standard-setting in psychiatry as a key activity. However, there is a marked lack of clarity as to what constitutes good and effective supervision and there are often few opportunities for learning how to supervise. Hayes (1996) writes about research supervision but his comments are equally applicable to other forms of supervision. He suggests that quality supervision, where it exists, is often by accident rather than by design. It is likely to have been acquired experientially and not without some past hurt to either supervisor or supervised or both. He argues that too much attention has been paid to the quality control of supervision and not enough to quality assurance, with insufficient attention paid to all the possible roles of a supervisor and the key personal attributes necessary to fulfil these roles.

This lack of understanding of, and training in, supervision may help to explain surveys of trainees highlighting dissatisfaction with supervision. Bools & Cottrell (1990), in a survey of senior registrar training in child and adolescent psychiatry, found that nearly one in four trainees did not have a regular hour of supervision per week, and nearly 10% of respondents reported no individual supervision at all. A further survey, looking specifically at supervision, found that only 80% of respondents received regular weekly timetabled supervision of at least one hour per week (Kingsbury & Allsopp, 1994). Herriot *et al* (1994) reported on a smaller survey of senior house officers (SHOs) and registrars in four health authorities. Only about three-quarters of the trainees were receiving weekly supervision, with up to one-quarter of trainees and consultants expressing dissatisfaction with the supervision process. A survey of consultants on one training scheme also concluded that even basic supervision standards were not being met and concluded that "the nature and purpose of supervision appear to be unclear to most consultants and trainees" (Azuonye, 1997).

It is of interest that while most of the studies cited above commented adversely on the frequency, regularity and duration of supervision, they also reported on the content of supervision. This is less easy to measure, partly because of the lack of clear guidelines as to what constitutes good supervision. Nevertheless, a surprising degree of consensus emerges about the suggested supervision content. This will be discussed in more detail below. Consultant supervision of general professional trainees has already been described (Robertson & Dean, 1997), and therefore this article will focus more on the supervision of specialist trainees. However, most of what follows would probably be applicable to supervision at all levels.

Many of the difficulties of supervision, as perceived by consultants, are concerned with the lack of clarity of the role of supervisor (see Box 1), but it must also be stressed that supervision is a

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Box 1. Common consultant concerns about supervision

Finding time
Uncertainties about boundaries
Giving effective feedback, both praise and constructive criticism
Helping the incompetent/unwell trainee
Balancing
   Direction v. *facilitation*
   Line management v. *trainee autonomy*
   Service v. *training needs*
   Trust v. *monitoring/checking-up*

potentially rewarding, stimulating and enjoyable experience. It provides an opportunity to watch trainees develop new skills and new ways of thinking, adds variety to the working day, and for many trainers is a stimulation to their own learning.

Learning theories

Psychiatric trainees are adult learners and bring with them to their training a wide range of past experience, learning abilities and styles. The motivation of adult learners is often stronger and their learning more purposeful than in earlier years. They want to learn in order to pursue a particular self-chosen outcome, and therefore require meaning and relevance in what is taught. They want active involvement in the learning process and usually expect clear goals and objectives, and require feedback and time for reflection. Training against this background has to manage a constant tension between a respect for the autonomy of trainees as mature adults and the need for the trainer to specify particular learning objectives as part of the requirements for successful completion of training.

Some knowledge of educational theory with respect to styles and processes of learning is helpful for supervisors. Schmidt *et al* (1990) describe a stage theory of clinical reasoning to explain the process of developing medical expertise (see Box 2). In the first stage, novices develop rich, elaborated, causal networks to explain the causes and consequences of disease in terms of general underlying pathophysiological processes. These models give structure and meaning to otherwise chaotic influxes of information. As learning continues these models become more elaborate, but the resulting perspective on disease is often rather prototypical with only limited understanding of the variability with which disease presents in the real world. In the second stage, exposure to patients results in these early networks becoming simplified into higher-level models that explain signs and symptoms. 'Short cuts' in clinical reasoning take place as the student learns to activate only relevant knowledge in understanding cases. In the third stage, further exposure to clinical material leads to the incorporation of other contextual factors in the internal model. Instead of causal processes, the characteristic clinical features of the disease become the anchor points around which the clinician's thinking evolves. Experienced clinicians develop 'illness scripts' as a means of storing and organising information about conditions. Clinical problem-solving becomes a process of comparing presenting signs and symptoms with existing internal scripts and looking for similarities and differences. In the final stage it is suggested that clinicians make increasing use of memories of actual patients to make judgements about new cases. Such experts are using 'instance scripts' to make rapid decisions based on similarities and differences between the current situation and recalled prior cases. At this stage they are not following a series of logical cognitive steps in the way that juniors are often encouraged to do at the novice stage. Elaborated causal models or general illness scripts are used only when similarity judgements fail.

Trainees may be at different stages of conceptualisation for different types of problem depending on past experience. Those who have been relatively senior in other fields before coming to psychiatry may attempt to use higher levels of thinking without the necessary relevant experience to base this on, leading to obvious problems. It may be helpful for supervisors to have a means of thinking about the thinking of their trainees. If supervisors can conceptualise different stages in the trainee's thinking about problems and assess which stage the trainee is using, this assessment can be shared with trainees during supervision. This will also help supervisors in thinking about their role within supervision,

Box 2. A stage theory of clinical reasoning (see Schmidt *et al*, 1990)

Stage 1: Development of elaborated causal networks
Stage 2: Compilation of elaborated networks into abridged ones
Stage 3: Emergence of illness scripts
Stage 4: Storage of patient encounters as instance scripts

particularly in relation to the shifts from relative direction to relative non-direction within one supervision session, which have to be made depending on which type of problem is being discussed.

Appraisal and assessment

Appraisal and assessment are both key skills for the effective supervisor, but are often misunderstood or muddled. Appraisal is primarily for educational purposes, is usually confidential and is designed to assist the progress of the learner. It is focused on the trainee and his or her needs and is designed to make training and learning more efficient and effective. The Royal College of Psychiatrists (1998) and the Department of Health (1998) both emphasise the importance of appraisal for trainees' development. Appraisal is an integral part of supervision and is likely to use the agreed training recommendations as a basis for discussion and review. However, trainers also need to write reports on trainees for their annual assessments with postgraduate deans and training programme directors. Assessment is concerned with career regulation and the measurement of the trainee against pre-agreed standards. It leads to decisions about career progress and therefore is not confidential. Managing the tension between these two conflicting demands is a difficult one for trainers and trainees.

Structure and content of supervision

Supervision will always be different for each trainer/trainee pair, and will differ from one session to the next according to the needs of training. The suggestions about the structure and content of supervision which follow are drawn from: my own experience of being supervised and being a supervisor; published literature on good supervision, including surveys of trainer and trainee views about supervision; discussion with colleagues; and feedback from a number of workshops that I have organised on supervision for the Royal College of Psychiatrists.

Structure

Although all supervision experiences will differ, they cannot be effective without a clear structure (Box 3) and explicit aims and objectives.

Ground rules

It is essential that ground rules should be agreed for supervision in the early stages of the supervisory relationship. These should clarify what it is appropriate to discuss, what the trainer and trainee expect of each other, and what to do if urgent problems require discussion between supervision sessions. There should be discussion and agreement about the likely content of supervision and liaison with the programme director about those areas that cannot be covered within the placement supervision. The boundaries of confidentiality must be established at the outset. It is essential that supervision sessions cover areas of difficulty for the trainee. This is more likely to happen if trainees know which aspects of their discussions will be confidential and used for appraisal purposes, and which will contribute to formal assessment reports. However, trainees and trainers need to be aware that no confidentiality agreements are absolute. From time to time the trainer may become aware of behaviour or performance which has to be shared with others, irrespective of the trainee's wishes, for example behaviour likely to cause significant harm to patients. In these situations it is good practice for trainees to be told exactly what the concerns are, and with whom they are being shared, before any third party is involved.

It is helpful if a written contract is drawn up specifying what has been agreed concerning timing, ground rules and content of supervision. This will make dealing with any subsequent difficulties in the supervision process much easier.

Timing

One hour of individual supervision per week is usually seen as the irreducible minimum. This should happen at a regular time and in a fixed place each week. The time should be protected as far as is possible from interruptions by pagers, telephone calls and demands of colleagues and patients. The creation of such a predictable space for supervision

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Box 3. Structure of supervision

Ground rules
Timing
Flexibility
Learning objectives
Record-keeping
Liaison with the programme director

helps to contain trainee anxieties and is likely to reduce demands from trainees for additional supervision time. If a trainee knows that supervision will be available at a particular time, the need for advice, help and support can usually be delayed until that time.

Although supervision should usually be on an individual basis, there are occasions when other models may be useful. If a trainer is supervising two trainees at the same grade, there may be occasions when joint supervision, with the opportunities this affords for sharing experiences, may be appropriate. If this does occur, sessions would need to be longer than the usual one hour per week. There would also have to be agreed mechanisms for either of the trainees to see the trainer individually if the need arose. Joint supervision is probably not helpful for supervising two trainees of different grades (SHO and specialist registrar (SpR)) except for occasional sessions with specific objectives, for example discussing the supervision of the SHO by the SpR.

Flexibility

Trainees will differ in past experience and, therefore, in current training needs. Trainers will differ with respect to the training opportunities that they can offer. The first one or two supervision sessions in a placement should, therefore, include a review of the trainee's prior training with a view to identifying gaps in experience and matching these to training opportunities in the forthcoming placement.

Thereafter, supervision sessions should be trainee-led as far as is possible. Trainees should be encouraged to come to supervision with an agenda of topics that they wish to be discussed. The supervisor should monitor the content of supervision over time and ensure that there is a good balance of the various subjects that need to be discussed (see below). The exact frequency of discussion of any one case or topic, and the depth of that discussion, will depend on the particular trainee's experience.

Learning objectives

As the 'Calmanisation' of training becomes established, early placement reviews will assume increasing importance. If trainees are to complete all training objectives within the time allotted for the acquisition of certificates of completion of specialist training (CCSTs), then training needs to become far more organised and managed. Annual assessments by programme directors and postgraduate deans will identify training needs and, increasingly, trainers and trainees will be expected to follow particular training paths. This process will be helped if trainees keep a log book/record of experience throughout training that can be used to plan future training needs.

It is likely that, in the future, trainers will not just be able to offer trainees experience of the generality of what happens in the placement. Instead, particular aspects of that placement may be singled out to meet training needs, and other areas not used for training at all. Similarly, trainees may not always be able to take advantage of all the training opportunities present in a particular placement. It is essential that, early in the placement, the trainer and trainee establish what needs to be done and prioritise this at the expense of what would be interesting to do. It is hoped that in well-managed placements there will be time for both. Producing a written list of essential and desirable learning objectives and the experiences necessary to master these objectives is a useful starting point to any placement. Many trainees now arrive in a placement with these, having produced them following annual assessments with postgraduate deans and programme directors.

The existence of clearly defined learning objectives for trainees can also be useful when dealing with trainees who, for whatever reason, have become demotivated. Constructing relevant objectives provides an opportunity for thinking about what kind of psychiatrist the trainee hopes to become, what skills they will need to carry out the job and how they can acquire those skills in training.

Record-keeping

Trainees should maintain and bring to supervision an up-to-date list of their current cases and the case notes of any patient that they wish to discuss, as well as their log books. They should also keep notes of any decisions reached in supervision and, if these concern patient care, record these in the patients' notes.

Trainers should also keep their own list of the trainee's cases to assist them in helping the trainee to monitor their workload, and should always know how many ongoing cases their trainee has at any one time. Unless they have exceptional memories trainers should also make notes about cases which are discussed so that they can: (a) monitor whether any cases have not been discussed for too long; and (b) remind themselves of previous discussions when cases are reviewed again. In the fortunately rare event of serious concerns about a particular trainee, the presence of accurate and contemporaneous records can be very helpful.

Liaison with the programme director

It is important for the trainee and trainer to be clear about the boundaries of supervision. It is usually

impossible for any one consultant trainer to provide supervision to meet all of a trainee's needs. Who provides training and supervision is less important than the fact that there is a clearly organised system which takes all trainees' needs into account and does not allow important areas to be neglected because everyone thinks that area is someone else's responsibility. All trainers should review all of the areas described below with their trainee and ensure that if they are not providing supervision, others are. Liaison with the programme director about the totality of supervision and training will be essential.

Difficulties within the supervision relationship should be resolved internally as far as is possible. However, every training programme should ensure that there is a way for trainees who are having difficulties in supervision to have access to outside help when needed. This might be via the programme director or perhaps another consultant designated specifically for this purpose.

Content of supervision

This is the most difficult aspect of supervision to specify. If the structures outlined above are in place, then trainers and trainees should have a good idea of what needs to be discussed in supervision. The *Higher Specialist Training Handbook* (Royal College of Psychiatrists, 1998) will, of course, spell out training objectives in some detail. The exact content of supervision will vary according to the needs of the trainee and the opportunities within the placement. However, supervision should always include the following (Box 4):

Clinical management

(a) Theoretical and practical management of cases. In particular, helping trainees to integrate theoretical and research knowledge into clinical practice.
(b) Management of case load and setting of learning objectives and priorities.
(c) In-depth supervision of particular cases.
(d) Supervision for specific therapeutic modalities, for example, individual psychodynamic psychotherapy.

Teaching and research

(a) Teaching skills training.
(b) Discussion of the learning and supervision process – an important component of supervision is reflection, by trainer and trainee, on the process of supervision itself, and consideration of whether the supervision is meeting the needs of the trainee.

> **Box 4. Content of supervision**
>
> Clinical management
> Teaching and research
> Management and administration
> Pastoral care

(c) Appraisal skills and the supervision of others.
(d) Research methodology teaching and research project supervision.

Management and administration

(a) Management skills training and provision of knowledge regarding medical politics and National Health Service structures.
(b) Issues concerned with the functioning of and working with multi-disciplinary teams.

Pastoral care

(a) Personal guidance and support. In particular, the supervisor has an obligation to bring up personal issues if he or she thinks they are affecting their trainee's capacity to work.
(b) Careers guidance.

Although it will not be possible, or appropriate, for all trainers to offer supervision in all of these areas personally, most supervisors should be able to provide some supervision. Thus, the local membership course or academic programme may provide some training in teaching skills, but the consultant supervisor may still be able to provide supervision of a particular teaching engagement during a placement. Similarly, many schemes provide separate research supervisors for trainees, but this should not stop consultants pointing out and discussing relevant research in relation to clinical work.

Additional training experiences

In addition to the minimum, one hour per week of supervision, there are a number of other activities which contribute to the supervision process. Trainers should endeavour to provide some or all of the following during placements, depending upon the nature of the placement and the needs of the trainee:

(a) Opportunities for the trainee to observe the consultant working in a variety of different settings including attendance at meetings or conferences with the consultant where appropriate.

(b) Observation of one session with a particular case, perhaps chosen by the trainee, as a way of providing more detailed supervision of complex cases. This might include live supervision of the trainee either individually or as part of a family therapy team, where appropriate.

(c) Joint work with the trainee.

(d) Opportunities for all of the above with other members of the team who have different skills to the consultant supervisor.

Conclusion

Supervision is one of the key mechanisms by which consultant psychiatrists seek to train their juniors and enable them to become consultants. Despite this, there are remarkably few guidelines available concerning the structure and content of supervision, although there is evidence that both trainees and trainers are dissatisfied with current supervisory arrangements. Very few consultants have had training in how to supervise and very few of today's trainees are receiving supervision in how to supervise, suggesting that supervision is not, necessarily, going to get any better.

Box 5. Skills required by supervisors

Observer reflector
Information provider
Identifier of alternatives
Facilitator
Joint problem-solver
Process counsellor
Negotiator
Advocate

Since the Calman report (Department of Health, 1993), much work has gone into producing clearer learning objectives for trainees, and lists of required learning experiences. Much less thought has been given to the skills that supervisors need to help trainees get the best from these experiences and achieve their objectives.

To be an effective supervisor requires many skills, for most of which consultant supervisors have not been trained (see Box 5). However, many of these skills are part and parcel of being a good clinician. With some thought, and a little effort, combined with dialogue and openness with trainees, any consultant can improve their supervision skills.

For further reading on the topic of this paper, readers are directed to Standing Committee on Postgraduate Medical & Dental Education (1996).

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