1 Introduction to clinical supervision

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Editors' introduction

In this chapter we offer a comprehensive definition of supervision taken from Hawkins and Shohet's *Supervision in the Helping Professions* (2012) and discuss its relevance to the medical profession. We recognize that supervision can mean many things to different people. Our aim has been to clarify how the term is used and to differentiate clinical supervision from educational and managerial supervision so that its value and relevance can be recognized whatever the background, speciality or career stage of the doctor. This chapter introduces some basic principles of supervision and looks at supervision from a number of different perspectives. We show how clinical supervision builds on reflective practice and illustrate how the authors use clinical supervision in practice. It goes on to explore the potential benefits of clinical supervision throughout a doctor’s career and puts in context other chapters in the book.

Overview of chapter

The medical profession is always seeking to improve patient care, look after its practitioners and increase efficiency of services. Our belief is that supervision has an important part to play in this. In this chapter, we share our perspectives on the different kinds of supervision, and focus specifically on clinical supervision and its benefits. The chapter is an orientation for the rest of the book, and it will be useful for those thinking about starting supervision, as well as those more used to giving and receiving supervision.
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Introduction

In this chapter we explore how regular ongoing clinical supervision can become a cornerstone for maintaining a doctor’s clinical work. We see clinical supervision as a resource that doctors can make use of throughout their professional life; a resource which can contribute to personal resilience and well-being as well as to the practical challenges that every clinician regularly faces.

We promote an eclectic approach to clinical supervision that complements the educational supervision to which many doctors already have access. We intentionally focus on clinical supervision as it relates to regular ongoing clinical practice although much of what is offered is equally relevant to clinical supervision of trainees. For many doctors ‘clinical supervision’ is associated with the supervisor knowing best and telling the supervisee what is right (super-vision, where the supervisor ‘oversees’ the supervisee). We describe in this book several models of clinical supervision that provide an opportunity for supervisees to ‘look anew’ at what challenges them, where the supervisor works to ‘enable and empower’ the supervisee to address clinical dilemmas. (Super-vision, where the supervisor helps the supervisee to see issues from a different perspective.)

Supervision describes a number of different types of encounter practitioners may have with another professional to enable their learning, development and support. Although the concept, language and style of supervision as we are using it may be foreign to some doctors, many of the activities of supervision already happen for doctors in a number of different settings such as case discussions, significant event analysis, appraisal, training, meetings with a mentor, practice meetings, or even just informal conversations (see Chapters 5 and 6). Many doctors experience supervision as a trainee and some have regular clinical supervision, for example trainee psychiatrists when they are delivering therapy. We suggest in this book ways that both doctors and patients will benefit through doctors having regular ongoing supervision.

What is clinical supervision?

The following is taken from the fourth edition of Supervision in the Helping Professions (Hawkins and Shohet 2012).

Supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationships and the wider systemic context, and by so doing improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession.

We recognize that the above is a long and complex definition, but we consider it essential to understand how supervision is a complex task which sets out to serve a number of key stakeholders. At a minimum supervision should be in service of:

- the learning and development of the supervisee;
- the patients of the supervisee and the quality of service they receive;
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- the organization(s) that employ the supervisee and the effectiveness and efficiency of the organization’s work;
- the ongoing learning and development of the profession in which the supervisee and, possibly, the supervisor work.

Done well, we believe that supervision can and should serve four or more masters. To better understand this definition we will look at each phrase:

**Supervision is a joint endeavour:** it is important that supervision is not seen as an activity done by the supervisor on the supervisee. Both the supervisee and the supervisor need to be working in partnership, standing shoulder to shoulder facing the challenges of the work, within a clear contract in service of the supervisee and the wider system.

... **in which a practitioner with the help of a supervisor, attends to their clients:** supervision always involves patients, otherwise it becomes a form of counselling at work. It provides the opportunity for supervisees to stand back and reflect on each of their patients so as to understand the patients better and what might best help them.

... **themselves as part of their client practitioner relationships:** we believe that an objective understanding of the patient is neither achievable or desirable but practitioners need to understand the patient in the context of their professional relationship, which entails reflecting on themselves as part of the relational context.

... **and the wider systemic context:** the relationships with the patients never exist in isolation, but always in a systemic context, which includes the organizational and professional context, the wider social and political context in which the organization operates, as well as the family and social context of the patient.

... **and by so doing improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession:** supervision is not just a reflective process but one that needs to produce learning and improvement outcomes for supervisees, their patients, their future practice, the organization and the profession.

As the above indicates, being in clinical practice means taking into account multiple points of view. Sometimes we have to try and ‘see things through the patient’s eyes’; at other times we need to maintain a very clearly objective perception. Moving between these perspectives is part of the ‘art of medicine’. One aspect of clinical supervision is reflecting on these different perspectives, identifying which is the most appropriate in any one setting and supporting the doctor who has to hold perspectives that do not ‘sit easily’ with them. The case that Emma, a general practitioner, brought to supervision illustrates this.
CASE EXAMPLE: EMMA

Emma is treating a man age 59 who has metastatic prostate disease. He had discussed with Emma his impotence secondary to hormonal treatment. He mentioned that he has not had sex with his wife for some time but that he is having an affair and is considering stopping his hormonal treatment. Emma is also treating his wife, who does not know about the affair. Emma describes feeling 'weighed down' by the secret she is carrying and also a 'little angry' with the husband. In supervision she is able to review the treatment and advice she has given, which is completely appropriate. She is able to look at why she is angry and to let out that it is more than 'a little anger' she feels. She feels taken advantage of and resents the husband, and she can recognize to some extent she holds this position as a surrogate on behalf of the wife. She is concerned that she will in some way breach the husband’s confidentiality and talking about it enables her to see that part of her wants the wife to find out. She is anxious that if the husband dies, the wife will find out and challenge Emma about what she knew of the husband’s affair. In talking it through, issues about confidentiality, including the principle that confidentiality is maintained even following the patient’s death, helped Emma clarify how she will manage her own attitude to ‘the secret’. In supervision Emma was able to rehearse what she would say to the husband next time he consults her. At a subsequent meeting Emma commented that because of the supervision she had felt able to respond differently to the husband and better about seeing his wife.

Tensions arising from seeing things from many different perspectives and conflicting priorities exist not just between doctors and patients, but also between the views and priorities of colleagues, different work environments, purchasing groups, professional organizations and even the government. In many instances doctors will be clear about the course of action that the situation requires, but sometimes they will have to manage their own uncertainty about what they should do, how they should do it, how to do it with the resources available or even how they feel about doing it, given these multiple perspectives which may conflict.

Doctors with high workloads, time pressures and administrative overload have every right to claim a space for themselves, to slow down, think in more detail about a case, brainstorm solutions, express their opinions and frustrations while exploring their own creativity. In addition they can ask for feedback, identify areas in which they want to improve and connect with their vulnerability. Clinical supervision provides an opportunity to do this. It poses important questions which are helpful to consider. As one doctor commented,

So much is about my attitudes and awareness – when these are transformed my way of working and my effectiveness are also transformed. It takes courage to show my work with honesty – the highs and the lows… Supervision gently illuminates my blind spots and monitors my safety and the safety of my patients.
Central to doing this is the safety of the supervisory relationship, which we explore later under contracting.

**Benefits of clinical supervision**

Clinical supervision offers practical ideas that can be tried and rehearsed in the supervision setting and provides a space for facilitated reflection, both of which we have found contribute to well-being. There is an opportunity to look deeply at why a particular issue has occurred, its relevance to the supervisee and the connection between an individual’s experience of a particular issue and the provision of care. Over the years of supervising and training supervisors we have found that patients benefit when doctors meet their own well-being needs (see Chapter 7) and have opportunities for personal and professional development. We foresee an opportunity for regular, ongoing clinical supervision to build on the more positive aspects of appraisal and reflective practice (see Chapter 9). We have found that regular supervision can improve the quality of the clinical relationship, itself a predictor of patient care and outcome. Supervision can contribute to breaking the cycle of stress and burnout (Nielsen and Tulinius 2009) that doctors are susceptible to and that might themselves be linked to making errors (West et al. 2006). In addition, supervision provides a structured reflective space to review management and care decisions, ethical issues and the relationship between patient, doctor and other members of the healthcare team. All these can impact on patient care and service provision. While few doctors currently have the opportunity to avail themselves of this sort of supportive supervision, we envisage a time when doctors will not only consider it their right to have access to such support, but will see it as integral to maintaining their personal well-being and professional persona. Many readers will be familiar with the feelings, when they hear about colleagues in difficulty, of ‘there but for the grace of God go I’, or, ‘it could easily have happened to me’ and, ‘it’s just a matter of time’. These common refrains when hearing doctors talking about colleagues in difficulty point towards the fear doctors have of what might happen to them. When we have talked to medical professionals about what is currently available in the way of support, especially through revalidation and appraisal, we detect in many a sense of disempowerment (‘more hoops to jump through’), that doctors feel vulnerable (‘better keep my head down and not own up that I need support’) or defeatism (‘it won’t stop the next Shipman’), or even a cynicism which increases as the gap widens between the reality experienced and the beliefs held (‘just tell them what they want to hear’). Our experience is that when doctors are supported through clinical supervision they are able to move beyond the feelings mentioned above. They start to get their individual needs met and address more positively their continued professional development (see Chapter 12). It is not a question of either keeping up to date or getting support, but of both working synergistically.

There is a slowly growing awareness that clinical supervision can make an ongoing contribution, as part of everyday professional life, throughout a medical professional’s career regardless of the doctor’s speciality (see Chapter 10 for a survey of the research). This in turn could address some of the cultural and organizational challenges that a modern healthcare system wrestles with. Colleagues we have supervised often
comment on their high level of stress and the impact this is having not just on them but also those around them – patients, colleagues and family. As one supervisee commented, his spouse thought he had become ‘hardened’ and ‘withdrawn’ since starting in a new job, but this was just his way of ‘protecting’ himself.

The doctor and patient communicate with each other on many levels and difficulties arise when aspects of the patient are not noticed or addressed by the doctor. Noticing what would otherwise go unnoticed and addressing what would otherwise be left out are part of the reflective process we are advocating in this book. For example, a doctor reflecting on a significant event may recall information from the notes or from previous meetings that he or she had not recognized at the time of the event. Equally this information may only surface after discussing the case with colleagues who had also seen the patient. Sometimes a significant event analysis will reveal aspects of our work we wish to have further training in or where we might proceed more cautiously. At other times we may remain unclear about what happened to cause a problem or uncertain how we would act differently. These are like blind spots that, until someone else helps us ‘see’ them clearly, are likely to remain unchanged. We each have our own individual ‘blind spots’ and areas we struggle to see or interpret clearly, and it is perceiving and exploring these that is so enhanced by clinical supervision. This in turn increases our ability to perceive patients more fully. Recognizing that we will all encounter situations that we are unsure about in which we will have to face our limits and uncertainty is part of professional maturity. This will help us in resolving important issues that may affect us in a way we do not initially understand or that we find difficult to manage. Such situations often include those patients we perceive as ‘dumping’ on us, those becoming dependent on us and so-called heartsink patients. It is often these patients that take up a lot of our time. Reframing them from individuals and situations that cause us problems to ones from which we have much to learn is often a key skill of those who seek to use clinical supervision regularly.

Roger’s case below illustrates how supervision supports doctors and can address feelings in the supervisee that need a time and place to be worked through, allowing reflection about what lies behind these feelings and the wider implications for clinical practice.

**CASE EXAMPLE: ROGER**

Roger is in one-to-one supervision and says that he keeps thinking about a patient he saw recently and he can’t ‘get her out of his head’. He talks about a Rwandan woman who consulted with him a few weeks ago. Since seeing her, the doctor has on several occasions had ‘flashbacks’ to the brutal torture the patient described of herself and of her relatives that were ‘lost’. The doctor is able to let some of his feelings out in a ‘safe place’ although he feels powerless and vulnerable when thinking about this event, and this is mirrored by his powerlessness to control when these thoughts ‘catch him out’. Roger is invited to talk about what particular part of the patient’s narrative evokes the strongest feelings in him. He talks about how the patient’s father...
had negotiated with those who were going to kill him and his family. Tears come to the doctor’s eyes when talking about the father offering to pay his attackers to shoot him and his sons rather than club them to death. The patient witnessed the atrocity but was powerless to intervene and was the only family member to survive. Roger is encouraged to explore when else he has similar feelings of powerlessness and vulnerability. He talks about his powerlessness to ‘make things better’ for this patient and other patients. He goes on to get in touch with his vulnerability in relation to making time from his busy job to see his own children and the ‘impossible choices a father has to make’. At the same time Roger is able to see that anyone would have been traumatized by hearing of these events but that it was difficult to recognize this at the time perhaps because his role of supporting the patient conflicts with his own emotional reaction to what he is hearing. Supervision helps him get in touch with his feelings and explore ways of managing his own vulnerability and powerlessness when having to also care for a patient. At a subsequent supervision session he mentions the ‘flashbacks’ have stopped and he feels grateful for what he learnt from his patient.

**Educational and managerial supervision**

There are overlaps and similarities between educational, managerial and clinical supervision but the emphasis and orientation of the supervision, role and experience of the supervisor and expectations and selection of issues to bring by the supervisee differ considerably. Educational supervision focuses on imparting knowledge and assessment (Launer 2006), while managerial (sometimes called administrative or normative) supervision often focuses on specific targets and performance.

**Educational supervision**

When the purpose is predominantly educational, then supervision complements an individual’s formal education. It plays a valuable role in moving theoretical understanding into practical competences. Educational supervision aims to develop ‘best practice’ with the help of a more experienced colleague that may be a tutor, mentor or role model. Students and junior doctors may look to more senior colleagues for guidance, and the strong and important ‘formative’ influence of this in forming the professional persona is well recognized (Kenny *et al.* 2003). Educational supervision may be part of developing professional artistry in conjunction with technical mastery, and provide an opportunity to explore the importance of feelings, including their central importance to learning experiences in early clinical years (Foster 2009). The educational supervisor, when able to look beyond a curriculum and respond to a supervisee’s individual learning needs, plays a major role in enabling a trainee’s learning and development (Kennedy 2009) to be situated within a context of professional community (Lave and Wenger 1991). In the right setting educational supervision helps participants to understand the perspective of the training establishment or regulatory body and how this shapes their relationship to their professional community.
Managerial supervision

Managerial supervision is often primarily about maintaining standards and coordinating practice with policies or guidelines. It is a powerful tool in exploring and developing clinical practice, using personal and professional resources efficiently and helping individuals and teams recognize and develop procedures and protocols. With an emphasis on ‘quality control’ and ‘efficiency’ it plays a part in recognizing the importance to performance of individual and team well-being and support. A key aspect of managerial supervision is to explicitly balance the emphasis between organizational goals and the supervisee’s individual needs. Managerial supervision is often provided to teams and is referred to as team supervision that may be provided by a member of the team, a manager or an independent facilitator or supervisor. It can significantly help individuals and teams to address performance problems, tensions between team members (or their roles), issues with guidelines, protocols or other ‘red tape’ and problems when individual and organizational values are not aligned. The emphasis, as with some forms of coaching, is often on the task that needs doing. The managerial supervisor aims to ‘normalize’ a doctor’s behaviour and actions for a particular team or organization. While a good manager may well have the clinical needs of the patient and the educational needs of the doctor in mind, their emphasis is often on monitoring the work of those they manage and improving the work towards the targets (or guidelines) of the practice or organization they are appointed by.

Clinical supervision

In clinical supervision the main external reference is the clinical relationship between patient and doctor. Although it is mainly about the work with patients it also includes the work environment. Whether the issue is between the supervisee and a particular patient or between the supervisee and a work colleague, the reference point is – ‘How does this impact on the supervisee’s ability to care for and treat patients?’ Clinical supervision supports and holds the supervisee, provides a ‘restorative’ function (Proctor 2001) to assist the supervisee in managing challenges and promotes resilience. Clinical supervision tolerates uncertainty (Mollon 1989) while providing an opportunity for doctors to restore their equilibrium and rehearse how they can manage situations differently. Although the emphasis will be different depending on whether there is primarily a managerial, educative or clinical purpose to the supervision, in practice the different functions of supervision can be, and often are, combined in any supervision process. At times the relationship between the supervisor and supervisee will need to shift slightly to enable the different functions to be attended to and this is covered by the contracting process and supervisory relationship.

Individual or group supervision

A supervisee may work one-to-one with a supervisor in individual supervision, or as part of a group of individuals or part of a team. Individual and group supervision have much in common but also some important differences. In group supervision participants have to share the time available to present their work or issue but often
the material one person brings is extremely informative and helpful to others. Group supervision can be cost-efficient and provide collegiate support. Group supervisors should be knowledgeable about group dynamics and how to manage groups, especially as more challenging issues can affect the way a group behaves. In experienced hands bringing the attention of a group to this change in behaviour can provide an additional resource for the supervisor and group.

**Contracting and the supervisory agreement**

The agreement between supervisor and supervisee sets the ground rules for the supervision process and the tone for the supervisory relationship. It provides both explicit and implicit points of agreement and processes for working through common difficulties. Unless the supervisee is very experienced it is normally the supervisor that takes the lead in initiating such aspects of the agreement. While the supervisor may initiate the discussion, it is important to realize the agreement is a dynamic one that unfolds and shifts over time to reflect the supervisee’s needs.

In all supervision there are third parties that influence the work that is done. How this is dealt with is established in the contract, and includes looking at issues of boundaries, confidentiality and consent. In educational supervision the third party is usually a training or regulatory establishment. In managerial supervision it is the team or organization that the doctor works in or for. While in clinical supervision it is the clinical care of the patient that is primary, and this can extend to relationships with colleagues and the well-being and resilience of the doctor (Burton and Launer 2003). Each has its place and works with real-life encounters with patients or colleagues but in each the intention is different.

Clinical supervision relies greatly on the relationship and agreement between supervisee and supervisor. It is ultimately the quality of this relationship and the agreement between supervisor and supervisee that determines whether supervision is effective or not. Hunt suggests that there needs to be a degree of warmth, trust and genuineness and respect between them (supervisor and supervisee) in order to create a safe enough environment for supervision to take place (Hunt 1986). The quality of the supervisory relationship needs to be sufficiently open, clear and responsive to allow the supervisee to present all aspects of his or her relationship with the patient, while at the same time to be able to explore the dynamic between the supervisee and the supervisor. An important part of what the supervisor does is to enable the supervisee to be more fully aware of what actually takes place in the supervision session, as this often mirrors what happens between the doctor and patient. For example, one supervisee, Jane, came to supervision with feelings of being persecuted by patients and working defensively. Jane commented:

I often feel that I am sitting at my desk, stuck between the lawyers behind my back with their knives out, and the computer with all the information the practice and government require me to collect in front. In this situation I feel completely alone with my fears and the expectations of others while I occasionally glimpse the patient in my peripheral vision.
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A conversation about the supervisory agreement that looked at confidentiality and consent brought out Jane’s fear that the supervisor was ‘judging her’ and that she could only ‘open up so far’. Once Jane and the supervisor had agreed on confidentiality and consent Jane was invited to reflect how she felt now, recounting her feelings. She felt vulnerable and uncertain about what the supervisor would think about her – even that he might ‘report her’ (this is an example of parallel process described in Chapter 2). By focusing on her feelings in supervision Jane recognized that they mirrored the feelings she had in her consulting room with a few dissatisfied patients. Jane explored what she needed to do differently with these patients and thought explaining to the patient about confidentiality and consent would help. After really ‘letting this sink in’ and being able to talk about managing patients’ dissatisfaction, and her own and her patients’ (unrealistic) expectations, she was able to understand her insecurities and fears.

The difference between reflective practice and supervision

If reflective practice is considered an intelligent conversation with oneself, then clinical supervision, on the other hand, is an intelligent conversation with another about a case or issue (Launer 2003). Reflective practice provides an opportunity to run through again, in our ‘mind’s eye’, what happened. It looks at the events ‘reflected’ in the mirror of our past experience and learning. Supervision in many ways starts from, nurtures and extends reflective practice. It encourages using reflective questions, not just during supervision but also as a regular part of managing challenging situations and consultations – such as, What do I think worked well? What questions are unanswered by this encounter? How do I imagine the patient or a colleague might comment on this interaction? What have I been left feeling and why? The asking of good questions is central to all types of supervision, reflective practice and coaching (see Chapters 4 and 8).

However, reflective practice on its own may leave unresolved some issues and feelings, and fail to explore fully patterns that repeat or raise questions the doctor is avoiding. Self-reflection can help us manage and cope with many challenges, puzzles and disappointments. However, if a reflective process is likened to seeing yourself in a mirror, then reflection may not, like a mirror, reveal what is under the surface of what is seen (Johns 1999), or even that the mirror itself may be distorted. Neither does reflection address assumptions or interpretations of what is being seen or avoided. To really gain insight into why certain issues reoccur for us or why certain ‘buttons get pushed’ often requires a separate point of reference, which a supervisor provides. Supervision brings an additional objectivity and may be thought of as holding an overviewing position. It is this perspective that distinguishes the process as ‘supervision’. Ideally someone who is able to view the supervisee and her work objectively provides supervision but at the same time the supervisee needs to feel confident the supervisor can empathize with her and can appreciate the context in which she works. Supervision by an immediate peer can help to move on from a completely personal reflective process but may lack the objectivity and challenge that an external supervisor brings.
Sometimes the challenge that supervision brings is very different from how reflection works, as the supervision of Jane illustrates.

**CASE EXAMPLE: JANE**

Jane was taking part in a group supervision that met for five days a year. When asked if there was a case or issue she wished to bring for supervision she initially said there was not anything too important. She went on to speak about how busy she was and discussed an issue related to time management. Later as the group was about to break for lunch Jane mentioned she really could do with some help with a very difficult patient. This patient was a registered drug addict with low self-esteem and always seemed to arrive at the most awkward time (like the time the issue surfaced in the group – just before lunch) with a deeply distressing complaint that Jane felt she was unlikely to be able to help with. There was an urgency and desperateness in Jane’s voice when she was talking about the patient and it evoked a desire in the group to support her. Jane described feeling tense talking about it and thought others in the group must be thinking her not good enough (like her patient). She commented she had reflected on why this patient was ‘difficult’ and had some strategies to cope but she seemed to have ‘lots of patients like this and just couldn’t go on’. The supervisor felt uncertain about addressing this case just before lunch and he pointed out that this case had not been mentioned earlier and the group was being put in a similar situation to the one Jane had been put in by the patient. The supervisor noticed his own feelings of uncertainty and being overwhelmed given how and when the issue surfaced. While acknowledging Jane’s obvious distress the supervisor shared his own feelings and invited Jane to reflect on whether these feelings mirrored her own in some way. Jane said they did. Despite Jane obviously being distressed, the supervisor felt that if they started this work with such poor contracting over time, then clarity and insight would be unlikely. Instead, he recommended they ‘park the issue’ and the group broke for lunch. That afternoon Jane was quiet and did not bring the case up again. Jane missed the next two groups and two members expressed disappointment that the group had not helped her (in a way the group was continuing to support Jane even in her absence). When she next came she shared that she had got significant insights from the group into how she was being sabotaged by patients like the one she presented (and that had been enacted in her dynamic with the group and supervisor). She went on to talk about why she worked so much with drug addicts and insights she had had on how to balance this work better with her other commitments. She commented that the supervisor and group making a choice not to deal with an issue ‘just before lunch’ modelled for her the ability to make some choices. Jane commented on being more aware of the ‘distressing content’ of her work and the need for a time and place for relaxation. Interestingly, her relationship with the patient had changed as he picked up her improved clarity around boundaries.
This is an example of how the supervisor was able to model a way of being around boundaries that carried over into the supervisee’s practice.

**Ongoing clinical supervision**

Ongoing supervision throughout one’s professional career has developed as an integral part of most of the caring and helping professions. In these professions it is a cornerstone of professional practice with regular protected time and resources. While many doctors recognize the value of supervision in training or as part of a remedial process, few see it playing a key role in their ongoing day-to-day professional practice (see Chapter 9). There are, of course, many external reasons why it is difficult for doctors to access regular ongoing clinical supervision once they have completed their training, such as lack of time, potential cost and lack of clinical supervisors. Talking to those who do use regular supervision, there is a sense that at some level that is not unique to doctors, it is difficult to engage with those things we find most challenging. For doctors perhaps it sits uneasily with the ‘hero’ or ‘warrior’ role that doctors have to develop – the ‘hero’ that daily supports patients who are distressed and facing major life events and the ‘warrior’ who battles against debilitating disease, having to make tough choices about life and death decisions. Perhaps in this environment it is difficult for doctors to sit with feelings of uncertainty, and even hard for patients to realize that doctors need help and support at times. It is understandable that those who wish to avoid this discomfort might find different reasons to avoid a process that brings these feelings to their attention. They may prefer instead to keep focused on the task in hand, creating a work pattern where there is no time for this reflective process, or trying to steer their work away from areas that remind them of their uncertainty (for a fuller discussion see the final chapter). In many situations doctors have developed strategies (some might say survival strategies in the complaints, fitness to practise and litigious environment in which we practise) to protect themselves from the diverse views, expectations and projections of others, whether colleagues, patients, managers or regulators.

Ongoing supervision offers an opportunity to examine when and how the different defences we set up (each at a cost to us and our work) are useful. While some are healthy coping mechanisms to the many challenges of medical practice, others when inappropriately held may jeopardize the care patients receive, threaten the well-being of doctors, or hold back professional development (see Chapter 9). For example, one aspect of the doctor–patient relationship that commonly surfaces in supervision of doctors is around issues to do with unrealistic expectations of the patient. This sometimes reflects patients’ expectation of the doctor: ‘But you always know what is best’ or ‘Just make me better’ (with, of course, its shadow – to be held responsible for what goes wrong). At other times it reflects doctors’ feelings that they must always have the answer (or the shadow – ‘whatever I do is not going to be enough’). This potent mix of idealization and unrealistic expectation makes it hard for doctors to ask for, and receive, regular support as they may have bought into the idea that they should know best. Once seen for what they are, the pressures from idealization and unrealistic expectations, to name just two ingrained beliefs, can be managed with more insight.

As you might expect, the sorts of issues and insights one brings to or gets through supervision depend in part on the frequency and context in which supervision takes
place. The insights available when the focus is as a one-off session looking at a specific problem are quite different from those that emerge in a course of supervision that invites reflection on all aspects of practice, which are again different from what emerges in supervision as part of an ongoing career-long process. For many, the first awareness that there is a process available to them for support and development is in itself a significant breakthrough, as the example of Ruth illustrates.

**CASE EXAMPLE: RUTH**

Ruth attended a course of four half days on supervision for doctors. In the initial session she wanted to concentrate on the different interventions that doctors in the group used when a ‘difficult to manage’ hypertensive patient presented. ‘What would you do?’ she challenged others in the group. After presenting a case at the second session where whatever advice was offered by the group was ‘not good enough’, the supervisor invited Ruth to talk about what it felt like when nothing was good enough. (An individual will often project onto others what they are feeling.) Ruth was able to notice that she often had the feeling of ‘not being good enough’ for the patient. She went on to say that she had the same feeling that she was not as good as others in the group and that she was thinking of leaving. Exploring this more, Ruth talked about feeling that whatever she did it was never enough. The supervisor invited the group members to comment on what they were feeling at this point. Several members resonated with what Ruth felt and many felt alone with the pressure of patients and their own expectations. (Usually an issue will touch several, if not all members of a group even though one person initially brings it.) One member commented that she often finds it ‘easier just to get on with things on my own than ask for help’. The group including Ruth went on to explore their fear of failure and how this fear was initially intensified rather than relieved when they asked for help. It was as if the fear of asking for help had covered up or displaced the fear of failure. Interestingly the next case Ruth brought to supervision was one where she felt she had done something wrong rather than one where she might ‘just have done better’. Invited to reflect on this she commented that she felt it was now all right to ask for help as others had also shown their vulnerability and she realized she had always felt her training was about ‘being strong’.

While many doctors are exquisitely compassionate, sensitive and alert to their patients’ needs, our experience is that they rarely focus these attributes on themselves or even colleagues. Under a banner of continued professional development a number of attributes and values have been championed to improve the safety and care of patients, but time is seldom made to bring the same humanistic and person-centred values and attributes to bear on their own and colleagues’ lives, or to examine the impact of their work on their relationship to family and loved ones. Ongoing supervision allows such issues to be addressed.
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Often it is only as we develop our clinical experience beyond our basic training that we extend our competencies to meet cases and situations that challenge our sometimes deeply held assumptions and values. When this happens, doctors need opportunities for deep reflection, as provided by the sort of supervision we are describing. As Fish and Coles (2005) say, membership of a profession brings with it the moral duty for professionals to be aware of the values (personal and professional) that drive their judgements and actions and the duty to recognize and take account of them as part of their on-the-spot responses. Using ongoing supervision is one way of understanding how behaviour, attitudes and values mirror themselves between the doctor’s personal and practice life. It offers an opportunity to explore the core meaning of being a professional (Fish and Twinn 1997) as someone who ‘seeks a broad understanding of their practice, paying attention not only to their developing competence, but also to the fundamental purposes and values that underpin their work’ (Golby 1993).

Initially in clinical supervision, issues presented are likely to be recounted with the emphasis on the patient or clinical situation. But over time, the issues supervisees bring to supervision often deepen and reflect the issues they recognize as shaping the way they work, that of course reflect in the patient care they offer and invite a more challenging approach that looks at the supervisees’ personal resonance to the issues presented. This leads to opportunities for change not only at the level of clinical practice but also at the personal level. That in turn has an impact on the culture of the teams and organizations we work in and with. Over time supervisees may address issues that at first would not have been contemplated by them.

An integrated approach

One framework that has helped one of us (David) to reflect on supervisees’ needs in different supervisory settings has been to think of doctors’ educational, support and development needs in three different contexts – the personal, the practice and the organizational. This framework allows the supervisee and supervisor to have a preliminary discussion about the focus of the supervision they are jointly undertaking, and to consider it in a broad context. It provides doctors with a structure to begin mapping the impact, challenges and opportunities of the accelerating healthcare reforms and increased complexity levels of reorganizations that most doctors are facing.

The educational needs link to more formal learning that is highlighted or directed in supervision, the support role may require a more caring function to explore and move through periods of challenge and uncertainty, while the development needs may include the inner change and the tranformational or reframing process that the supervisee may need to go through. Different doctors often find they identify with problems in some of the grids, but find it more difficult to talk about or see issues in others, although this may change at different stages of one’s professional career. In practice, shifts in one area of the grid often provide an opportunity to explore the implications in other areas as well. As such, the ‘matrix’ can be a useful mapping tool for the supervisor as well as the supervisee. Table 1.1 gives examples of issues that might present but that might be different depending on whether the focus was more on educational, managerial or clinical supervision. We would encourage supervisees
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Table 1.1 The supervision matrix

<table>
<thead>
<tr>
<th>Education</th>
<th>Support</th>
<th>Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>Being told new information, I might have done it differently</td>
<td>Being heard – I’m not alone with this</td>
</tr>
<tr>
<td>Practice</td>
<td>Learning from how others work</td>
<td>Sharing practice problems</td>
</tr>
<tr>
<td>Professional/Organizational</td>
<td>Establishing best practice</td>
<td>Knowing about professional norms and how I fit in</td>
</tr>
</tbody>
</table>

To reflect on and identify their needs in each area and consider especially those areas they might not immediately be attracted to, or that do not initially ‘jump out at them’ as difficulties in one part of the matrix are often linked to challenges in others. For example, when doctors have perceived they have made errors in their practice, they might not immediately see the link to lack of support, burn out or feeling depressed (West et al. 2006).

Summary

Supervision’s primary purpose is sometimes taken to be to develop the supervisee at work and to ensure the welfare of patients (Carroll 1996). Different styles of supervision seek to achieve this in different ways and many supervisors will carry a mix of roles. Broadening the range of issues that can be addressed in any supervisory relationship is key to understanding why patterns of behaviour develop and are maintained. Exploring the issues more deeply, and uncovering the underlying attitudes and values that determine how we act, makes significant and sustainable change possible in our practice for our own well-being and the welfare of patients.

Supervision as we describe above, and throughout this book, explores the relationship between doctor and patient, helping to uncover hidden aspects of the supervisee (and supervisor) that represent blind spots in our clinical work. It provides a chance to understand and respond to situations in a more aware way, sometimes breaking patterns of response that have been repeated many times or that are ingrained in our behaviour. This in turn can transform how we engage with situations we previously found difficult. As one supervisee said,

It transformed what I considered to be wounds, which I had unknowingly kept hidden, to something that was an opportunity and challenge to change, and that now is something I am happy to talk about and reveal to others like a battle scar I am proud to carry.
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While recognizing that there is a legitimate fear of ‘supervision for supervision’s sake’, we must also recognize that there is a reluctance to look at things closely in case we do not like what we see. Many doctors already work to the highest motives and we wish to support this while encouraging practices and reflection that enable us to glimpse aspects of our work from a different perspective – what we might call the ‘aha’ moment (Owen 2007). Often the way the supervisee and supervisor personalize and extend the way they work is reflected in the working agreement between both parties in what we call the supervisory agreement.

Clinical supervision supports doctors in coping with the variety of stressful situations that clinical practice brings, including talking about issues concerning feeling uncertain and disillusioned. While making the support of the doctor (supervisee) explicit, this is done in the knowledge that, when well supported, the doctor is more likely to be able to offer a higher level of care, to notice and respond to educational needs, and to work towards team and organizational goals.

Note

1. Hawkins and Shohet use the word client in relation to the helping profession but we think this can be interchanged with patient.

References

Launer, J. (2006) Supervision, Mentoring and Coaching: One-to-One Learning Encounters in Medical Education. Edinburgh: Association for the Study of Medical Education.
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