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Who's happy with supervision?

AIMS AND METHOD

All psychiatry trainees and supervisors on the Southeast Scotland scheme were invited to complete a questionnaire about the regularity, responsibility, structure, content and value of supervision.

RESULTS

Significantly more supervisors (87%) than trainees (69%) reported regular supervision. Some trainees still find it difficult to obtain regular supervision. Although it is seen as a joint responsibility, there is uncertainty about the role and responsibility of each trainee and supervisor. Most trainees and supervisors feel that supervision is useful, but supervisors are likely to rate their quality of supervision better than their trainees. Guidelines for the structure, content and boundaries of supervision might be useful. Supervision is viewed as useful for discussing clinical management, including the trainee's own case-load.

CLINICAL IMPLICATIONS

Training in the use of supervision should be available to all trainees and supervisors. Regular supervision should be a priority, and it is a joint responsibility to ensure that it happens. There should be greater accountability to the College and Trusts. Discussion of the trainee's clinical case-load during supervision is a necessary part of training and the supervision process.

The Royal College of Psychiatrists expects all trainees in this specialty to have a weekly, protected hour with their educational supervisor, not directly related to a discussion of immediate clinical problems. Training consultants are expected to be readily available for this time, which should be exclusively for the trainee's benefit (Cottrell, 1999). Previous surveys have shown that between 76% (Sembhi & Livingston, 2000) and 80% (Kingsbury & Allsopp, 1994) of trainees have regular weekly timetabled supervision. Herriot *et al* (1994) reported that up to a quarter of trainees and consultants expressed dissatisfaction with supervision. Trainee psychiatrists have indicated that they want regular assessment of their skills, and constructive feedback about their performance (Day & Brown, 2000). Guidelines have been suggested for the structure and content of supervision (Cottrell, 1999).

No recent study has evaluated the quality of supervision in Scotland. We aimed to elicit the extent to which regular supervision takes place within the Southeast Scotland training scheme, by examining the views of trainees and supervisors, based on their most recent experience of supervision. The Southeast Scotland training scheme is one of the largest rotations in Scotland, covering Edinburgh, Midlothian, East and West Lothian, the Borders and Fife, with 72 full-time training posts.

Method

We devised a questionnaire that assessed the timing and duration of supervision, protection of supervision time and responsibility for supervision. We assessed the structure and quality of initial and subsequent sessions (Table 1). Using existing literature (Cottrell, 1999; Royal College of Psychiatrists, 2003) and discussion between the authors and colleagues, we identified potential topics and asked whether these had been discussed during supervision (Table 2). Finally, we asked each respondent to rate the usefulness of their experience of supervision (Table 3). Opportunity was also given for comments, which were evaluated qualitatively.

After a small pilot study, the final questionnaires were sent out in January 2003, at the end of the 6-month senior house officer (SHO) posts, to 69 SHOs in two Scottish basic specialist training schemes – Southeast Scotland and the Borders – and to 71 consultant supervisors at the Royal Edinburgh Hospital and associated hospitals in Fife, East and West Lothian, and the Scottish Borders. Identification numbers were allocated to allow a second round of questionnaires to be sent to non-responders. Raw data were entered into a database and analysed using the Statistical Package for the Social Sciences for Windows, version 10.1. Comparison was made primarily between consultants and trainees on

Table 1. Reported structure and quality of supervision

	Consultants *n*/N (%)[1]	SHOs *n*/N (%)[1]
Ground rules were set	31/45 (69)	19/48 (40)
Expectations were discussed	39/46 (85)	32/48 (67)
Review of prior training done	44/46 (96)	36/48 (75)
Learning and training goals set	41/46 (89)	37/48 (77)
Educational plan written	31/46 (67)	29/48 (60)
Pre-set agenda, each session	6/47 (13)	12/48 (25)
A written record of each session should be kept	9/35 (26)	11/32 (34)
Logbook is regularly updated	26/40 (65)	23/45 (51)
Logbook is useful	22/37 (60)	18/45 (40)

SHO, senior house officer.

1. *n*, number agreeing; *N*, number responding; % calculated according to the number who responded to each item.

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the main outcome measures, which were practicalities, attitude and perceived usefulness of supervision. Further analysis was carried out to identify potential confounders and the results were corrected if necessary. Data were analysed mainly by χ^2 testing and by *t*-tests for comparison of means where appropriate.

Results

Completed questionnaires were returned by 49 (69%) consultants and 51 (74%) SHOs, giving an overall response rate of 71%. The rates for men and women were similar: 63 males (74%) and 35 females (75%) responded. The mean age of responding consultants was 44 (range 33–58) years; 29% were female. The mean duration of experience was 10 (s.d. 7) years. Nineteen of the consultants (39%) had received formal training in supervision, of whom 13 (77%) found it useful. Of those who had not received formal training, 23 (82%) felt that it would have been beneficial. The mean age of responding SHOs was 30 (range 24–49) years; 41% were female. The mean training duration was 29 (s.d. 17) months, and 73% had received their undergraduate medical training in the UK.

The proportion of consultants (87%) reporting setting aside a regular protected time for supervision was significantly greater than the proportion of SHOs (69%) reporting that they received it. Ensuring that supervision occurs was seen as a joint responsibility by 82% of both consultants and SHOs. Alternative arrangements were made for missed sessions by 40% of consultants and 36% of SHOs. Women (43%) were more likely than men (35%) to make alternative arrangements. For those who reported regular sessions, the mean duration of each session was 54 (s.d. 13) minutes for consultants, and 50 (s.d. 14) minutes for SHOs. Those who had supervision at intervals other than weekly reported a longer duration of 75 (s.d. 30) minutes for consultants, and 59 (s.d. 37) minutes for SHOs.

Consultants were more likely to recall the setting of ground rules, discussion of expectations and a review of the trainee's prior training, than were SHOs. Only a minority of trainees and supervisors regularly set an agenda or kept a written record. Many failed to indicate whose responsibility it was to ensure the setting of an agenda, recording of sessions, or by whom the educational plan was held. The majority felt that keeping a written record was unnecessary. The trainee logbook was updated regularly by more than half of responders, but many failed to indicate how frequently this was done. Of those who did, the most common practice was to update it every 3 months. Many respondents (60% of SHOs, 41% of consultants) did not feel that the logbook was useful (see Table 1). Consultants more frequently reported that suitable topics were being covered, compared with SHOs. In particular, consultants more frequently reported giving feedback on the trainee's performance and written work (Table 2).

Supervision was found to be useful: consultants and SHOs rated each function equally, except that SHOs rated its usefulness in the management of individual clinical cases more highly than did consultants (Table 3). This seems at odds with the statement of purpose of formal supervision, as advised by the College.

Discussion

Consultants rate their quality of supervision more highly than do SHOs. Supervision is still seen as 'given' by consultants and 'received' by trainees and is not yet a

Table 2. Content of supervision sessions

	Consultants *n*/N (%)[1]	SHOs *n*/N (%)[1]
Clinical management	44/46 (96)	46/47 (98)
Evidence-based medicine	36/44 (82)	31/46 (67)
Research methodology and teaching	20/44 (45)	12/46 (26)
Research project supervision	15/44 (34)	8/47 (17)
Management and administration	38/44 (86)	34/45 (76)
Working within a multi-disciplinary team	41/45 (91)	41/47 (87)
Discussion of the learning and supervision process	30/43 (70)	33/47 (70)
Feedback on performance	44/45 (98)	40/47 (85)
Feedback on written work including note-keeping	36/44 (82)	29/47 (62)*
Presentation skills (e.g. meetings, case-conferences)	29/44 (66)	24/46 (52)
Teaching the trainee to teach others	11/44 (25)	9/43 (21)

SHO, senior house officer.

1. *n*, number agreeing; *N*, number responding; % calculated according to the number who responded to each item.

*P=0.04.

Table 3. Rating of the usefulness of supervision

	Consultants scores[1] Mean (s.d.)	SHOs scores[1] Mean (s.d.)
Usefulness of supervision for		
Career guidance	6.8 (1.9)	6.9 (1.8)
Management of own clinical cases	7.0 (2.7)	8.2 (1.9)*
Exam preparation	6.6 (1.6)	6.3 (2.5)
Education in general	6.7 (1.8)	7.0 (1.6)
Pastoral care	6.6 (2.2)	6.1 (2.8)
Performance feedback	7.9 (2.1)	7.3 (2.3)
Building a personal relationship	6.9 (1.8)	6.9 (2.3)

SHO, senior house officer.

1. Usefulness was rated on a scale from 0 (not useful) to 10 (very useful).

*P=0.02

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dialogue. Uncertainty about the responsibility of each party persists. Consultants reported the discussion of a greater number of issues compared with trainees. These findings might reflect differences in expectation and satisfaction; trainees may be uncertain of what to expect from supervision, whereas consultants have greater experience of the process. The trainee might expect to be given nuggets of wisdom, or an impromptu tutorial, whereas the consultant may expect the trainee to lead in an informed discussion. Trainees may feel unable to communicate their difficulties with the availability and adequacy of supervision from their consultant, who may not realise the full extent of their supervision needs. Trainees might still feel distanced from their supervising consultants, the majority of whom continue to be middle-aged men.

Among the consultants, the reasons for not giving supervision included time and workload constraints. Consultants may have several trainees to supervise, placing greater demands on their time and attention. Trainees had similar practical problems, but some had difficulty accessing their consultants because supervision was seen as a low priority. A small number of trainees stated that since they received 'on the job' contact with their consultant, formal supervision was unnecessary. Such comments indicate an overemphasis on clinical management and service provision, which falls short of good training requirements and breaches College guidelines.

There was a perceived lack of clear guidance on what to expect from supervision. The current divide between clinical and non-clinical supervision is seen as artificial, and may risk trainees' difficulties with their case-loads being overlooked. We found that clinical management and the management of the trainee's own cases are often discussed during supervision, and trainees rate this function of supervision highly. Our view is that the discussion of difficult or interesting cases can be a common starting point for further exploration. Trainees may also value the added reassurance of discussing clinical problems outside the setting of ward rounds or team meetings, which can be busy and often service-oriented. Clearly, clinical management should not be discussed at the expense of the trainee's other training needs, but we feel the current requirement to exclude it is potentially unhelpful.

Most trainees experience discussion of a wide range of topics during supervision (Table 2). Other topics that trainees would like to discuss include career aspirations, research possibilities, psychotherapy and personal support mechanisms. It was commonly acknowledged that setting an agenda in advance would improve the focus of sessions. However, only a minority did this in practice. Consultants felt that trainees could take a greater responsibility for the organisation of supervision. Conversely, some trainees felt their supervision was not adequately prioritised by their consultant. Formalising arrangements and recording sessions might improve accountability, but at the expense of increasing bureaucracy.

There is ambivalence about the use of the trainee logbook, with some trainees describing it as useful and others as 'yet another paper exercise'. Most trainees did not indicate how frequently they updated it. This training scheme has recently made the updating of logbooks a requirement for the Record of In-Training Assessment, and failure to do so may become a disciplinary issue. Introducing a requirement to record supervision was unpopular as most trainees and consultants do not want more paperwork. However, initial training on making the best use of supervision might be of value.

This is the first study done in Scotland, involving a large training scheme. We feel that our findings reflect a wide geographical area of Scotland, although they might not be easily generalised to the rest of the UK. Our overall response rate of 71% is comparable with other studies in this area (Kingsbury & Allsopp, 1994; Sembhi & Livingston, 2000), but we cannot exclude the possibility that our study was biased by preferential responses from those more dissatisfied with the supervision process.

Suggestions for improving supervision

Although most trainees found supervision helpful, some were not happy with its quality. Consultants may not be fully aware of their trainees' dissatisfaction. Trainees and supervisors are unsure how to make best use of the time, and would value a clearer understanding of its purpose. Despite being viewed as a joint responsibility, there is an expectation that trainees are there to receive what the supervisor provides. We propose that an 'introduction to supervision' session should be made available to trainees. This could advise them of suggested guidelines and topics, thus encouraging active participation and planning. A similar session should be available to all supervisors, few of whom have had training in supervision. Supervision should be jointly assessed and recorded regularly, perhaps tied into the initial, mid-point and end-of-post discussions already required by postgraduate deans for training posts in all specialities.

Time should be prioritised. The College requirement is clear, yet a significant proportion of trainees are not receiving regular supervision. Most health care trusts generate feedback forms to SHOs about their post. These could be used to identify posts without adequate supervision, and the information provided for inclusion in consultants' annual appraisals.

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Declaration of interest

None.

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