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SATI SEMBHI AND GILL LIVINGSTON

What trainees and trainers think about supervision

AIMS AND METHOD

A confidential questionnaire was mailed to all trainers and trainees on the UCL/North London rotation (n=127), asking about the content and ways of improving supervision.

RESULTS

Seventy-six per cent of trainees received regular, timetabled supervision. Ninety-four per cent of trainees felt it was a good idea, but identified improvements, including more planning, setting an agenda and flexibility. There were differences between reports from trainers and trainees regarding the content of supervision. Respondents' comments are included.

CLINICAL IMPLICATIONS

Although supervision is popular and widely practised, this survey suggests that it is still not universally practised despite College stipulations. The content of supervision could be broadened to include more non-clinical matters such as teaching and careers guidance.

The Royal College of Psychiatrists stipulates that all psychiatrists in training should receive regular, timetabled, weekly supervision by their trainer. Specialist registrar (SpR) training guidelines (Royal College of Psychiatrists, 1998) do not quantify the time-period. It is specified, however, that senior house officers (SHOs) should have a "protected hour per week" with their educational supervisor (Cottrell, 1999). As supervision is a relatively new requirement, very few trainers will have been supervised – let alone trained in supervision. Informal discussion suggests that the practice of supervision varies widely. It has been emphasised that supervision should be based on the needs of the trainee and, hence, will vary over time, but should be structured with clear aims and objectives (Cottrell, 1999). Cottrell suggests that good supervision should cover the following topics: clinical management, teaching and research, management and pastoral care. However, he points out that it may not be possible for all trainers to offer supervision in each of these areas personally. Previous research (Herriot *et al* 1994; Azuonye, 1997) has found approximately three-quarters of trainees in London received weekly supervision, but that many trainees and trainers were dissatisfied with it.

The aim of the project was, therefore, to find out trainers' and trainees' views about the purpose and content of supervision and the practicalities of current practice. This information could then be used as a basis for suggestions to improve and standardise supervision.

The study

All trainers and trainees on the University College London/North London psychiatry rotation were sent a questionnaire asking about their current supervision practice and experiences. This was devised from literature regarding the purpose and content of supervision (Herriot *et al*, 1994; Robertson & Dean, 1997; Royal College of Psychiatrists, 1998; Cottrell, 1999). The questionnaire was piloted and amended as necessary. The final questionnaire began with questions regarding the concepts of supervision and had open questions regarding the ideal content and time spent in supervision. The second part consisted of a list of the possible content of supervision and asked respondents to tick 'yes' or 'no' for each category (see Table 1). We also asked how long was spent in supervision and there was a space inviting respondents to make comments.

Initially, we numbered the last page to enable us to identify non-respondents and so gather as complete a data set as possible. This page was then discarded to preserve anonymity. Those who had not returned the questionnaire after the first mailing were sent it once

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Table 1. Topics covered by existing supervision, according to trainees and trainers

	Trainees (%) *n*=55	Trainers of SpRs (%) *n*=17	Trainers of SHOs (%) *n*=40
Clinical management	45 (82)	15 (88)	36 (90)
Teaching you to teach others	7 (13)	11 (65)	9 (23)
Research	24 (44)	16 (94)	20 (50)
Management training	18 (33)	12 (71)	10 (25)
Working within the multi-disciplinary team	30 (55)	15 (88)	35 (88)
Pastoral care	30 (55)	11 (65)	34 (85)
Exam practice/case presentations	28 (51)	1 (6)	31 (78)
Presentation at meetings	19 (35)	5 (29)	17 (43)
Setting learning objectives and priorities	35 (64)	11 (65)	28 (70)
Feedback on performance	34 (62)	15 (88)	34 (85)
Reviewing case note entries and letters	37 (67)	3 (18)	23 (58)
Supervision in report writing	14 (25)	11 (65)	25 (63)
Careers guidance	36 (65)	13 (76)	35 (88)

SpR, specialist registrar; SHO, senior house officer.

again. The length of time spent in supervision was calculated to give a weekly figure.

Findings

Respondents

The overall response rate was 97/127 (76%). Completed questionnaires were received from 55/75 (73%) trainees and 42/52 (81%) consultants (17 consultants worked with a SpR and 40 consultants worked with an SHO).

Ninety-four of all respondents thought that supervision was a good idea but three did not. The ideal time suggested ranged from 0–300 minutes with a median time of 60 minutes (s.d.=32).

Supervision of trainees

Forty-two (76%) of the trainees received regular, timetabled supervision, three (6%) received none, four (7%) had it timetabled, but in practice rarely received it and three (6%) received it although there was no timetable. The time reported spent in supervision per week by trainees ranged from 30 to 120 minutes (median 60; s.d.=16). Thirty-four (62%) had an agenda for supervision and 16 (21%) did not. Twenty-nine (53%) felt it was based on their needs whereas four (7%) did not.

There was a disparity between trainees' reported experience of supervision and what trainers said they did (see Table 1). These are particularly marked in the areas of teaching, research, management training, working with a multi-disciplinary team, pastoral care, feedback on performance and supervision on report writing. Supervision for SpRs and SHOs was constituted differently. Clinical management was covered in most trainees' supervision at all levels. However, SpRs were more likely to receive supervision in teaching, research and management. SHOs were more likely to receive pastoral care, exam practice and supervision on written work.

Trainees' comments

A consistent theme was the need to plan the time for supervision. Several trainees mentioned that they had not had supervision over a period of years. In addition, many trainees commented that supervision could not be dichotomised into being either useful or not. Instead, it depended on their individual needs at any one time (e.g. if sitting an exam); the demands of the job; and the ability and willingness of the consultant to supervise.

> "An hourly scheduled meeting often ends up with nobody knowing how to use it . . . an hour will be insufficient for some junior psychiatrists but may make the trainer feel they have done their job."
>
> "It depends on the consultant, my experience has been very variable."
>
> "A clear lack of training and supervision for supervisors."

In addition, trainees felt they should take some responsibility for their own supervision.

> "It is a flexible arrangement between the trainee and trainer and it takes two to tango."

Some trainees felt that supervision should take place on a day-to-day basis, for example, at ward rounds and out-patient clinics and in informal settings.

> "I think that a lot of supervision can take place on the hoof and sitting down at a specified time doesn't necessarily get more things done."
>
> "The idea of going for coffee and being a bit more human."

Other trainees felt that the value of supervision was that it could be individually tailored to their needs. One trainee commented that they wanted an insight into the life of a consultant, rather than the traditional help with their own role.

A few trainees commented on the ability of supervision to build up a personal relationship, "chit-chat, gossip and light-hearted chat". In contrast, others felt that given the hierarchical nature of the medical profession, personal relationships and pastoral care were impossible.

> "Impossible to use supervisor as pastoral carer . . . you want the boss to think you're efficient, competent and dedicated . . . unrealistic to express negative feelings about the job . . . at some point we will ask them for a reference."

There was an awareness of pressure on consultants' time and on trainees' time: "if consultants don't have the

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time, they need to be given it". One trainee had compromised on half an hour a week of supervision because of study leave and clinical commitments.

Supervision by trainers

Of the 17 consultants working with SpRs, 15 (88%) were supervising, one did so sometimes and one did not. Ten (59%) had an agenda for this supervision and two (12%) did not. The length of time spent supervising SpRs ranged from 4–60 minutes per week (median 55, s.d.=25).

Thirty-eight (92%) of the 40 consultants working with SHOs were supervising them. One consultant had supervision timetabled, but other commitments prevented it taking place every week and one consultant did not reply to this question. Twenty-six (65%) had an informal agenda for this, seven (18%) did not and one (3%) did sometimes. The length of supervision ranged from 30–60 minutes per week (median 60, s.d.=12).

Trainers' comments

Many trainers wrote that there was a need to be flexible about supervision and to consider the trainees' level of experience in planning both what to cover in the sessions, and how much time to offer them.

> "Definitely for SHOs. SpRs – probably, though not quite as clear there is a need for this to be as frequent."
>
> "Weekly time will be appropriate for more junior doctors – or for trainees inexperienced in a setting. This can then be reduced to a minimum of once a month."

Some felt that an hour was an excessive amount of time.

> ". . . protected time is necessary, but an hour can seem excessive."
>
> "I find it hard to keep going in responsive mode for more than 30–45 minutes."

Several consultants wrote that supervision should not be divorced from day-to-day work, or confined to a specific time, but should take place during normal duties.

> "Learning should be an apprenticeship, that is, the trainee should be with the trainer in different clinical settings, learning by experience, discussion, modelling, etc."

One commented that trainees were sometimes "less interested in supervision".

Many consultants found it difficult to find sufficient time in busy schedules to supervise trainees for 1 hour every week, particularly where they have more than one trainee ". . . but when I have two or more SpRs, an SHO and other trainees it becomes impossible to find 1 hour for each of them". They were also aware of the time pressures faced by their trainees: "every couple of weeks does seem like plenty when everyone's busy."

One consultant felt that supervision should include the opportunity for trainees to see what it is like being a consultant and learning strategies to cope with the job.

Discussion

Twenty-four per cent of trainees were not receiving weekly, timetabled supervision. This is consistent with previous research (Herriot *et al*, 1994; Azuonye, 1997), but is surprising, considering it is a College requirement. The content of supervision appeared to be based on clinical matters. Azuonye (1997) also found clinical issues dominated supervision time, which some of his respondents described as a continuation of the ward round. This highlights the fact that there is still scope for improvement. For example, the content of supervision could be broadened to include the other important areas of teaching and research, management and pastoral care as suggested by Cottrell (1999).

It is unclear why there was a disparity between trainees' and trainers' reports of the content of supervision. It may be that some aspects of supervision are more concrete than others, for example, practice for exams as compared with management training. Trainers and trainees may have different perspectives on what constitutes supervision in each of the specified areas. Creating an agenda for supervision may help clarify this, but less than two-thirds of trainees did this. The difference between the constitution of SpR and SHO supervision may, in part, be related to the trainee's level of experience and hence, their needs. However, it would be expected that other aspects of supervision such as careers guidance, pastoral care and giving feedback on performance would be relevant to all trainees.

Trainees emphasised the need for planning and structure to supervision, but also the value of flexibility. Both trainees and trainers were aware of time constraints. However, the duration of supervision should be based on trainees' needs, rather than dictated by pressure of work. This highlights the fact that supervision is time consuming and this has financial implications. The value of informal supervision was also acknowledged, with some trainees and trainers wanting supervision to take place in the real clinical world. This perhaps links in with the idea that trainees should also have the opportunity to observe their trainer at work in different settings (Cottrell, 1999).

The limitations of this study are, first, that it looks at the practice of supervision across only one rotation and this may differ from others in the country. Second, not everyone completed the questionnaire. However, the anonymity of replies is likely to have encouraged accurate reporting.

Supervision is popular among both trainees and trainers and should be available for all trainees. Trainees would like it to cover more than just clinical management and include topics such as teaching, research, careers guidance and presentations. The content should be organised with clear, but flexible, agendas. Both trainers and trainees should share responsibility for ensuring it takes place. The College should ensure it is provided for all trainees. There may also be a place for offering consultants training in the practice of effective supervision.

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MARK DAVIES

Towards the development of a reciprocal liaison service

A survey of attitudes

AIMS AND METHOD

The aim of this survey was to determine attitudes among consultants in different specialities towards the development of a reciprocal liaison service providing access for psychiatric patients to medical and surgical liaison services equal to the access of medical and surgical patients to psychiatric liaison services. All medical, surgical and psychiatric consultants in a district health service were surveyed, with a total response rate of 48%.

RESULTS

The mean number of medical and surgical patients requiring a psychiatric liaison service was 6%. The mean number of psychiatric patients requiring medical and surgical liaison services was 11%. Ratings overall for various components of the two types of liaison service were generally similar, with acute assessments and follow-up being given a high priority for both types.

CLINICAL IMPLICATIONS

As liaison services are developed, the notion of equity of access for all patients is paramount. Commissioning of such services should thereby specify the reciprocal nature of development. This survey shows that generally there is a positive attitude to the development of such a service.

Psychiatric liaison services for medical and surgical patients are a well-established, although often under-resourced and underdeveloped, feature of most local health services. Studies consistently show that this type of service reduces hospital stays and, ultimately, costs (Smith *et al*, 1995; Hall & Frankel, 1996). However, a clearly defined reciprocal service provided by medical and surgical services for psychiatric patients is poorly researched and developed. Cooperative intervention between physical and mental health services can improve detection and management of 'cross-speciality' disease (Saravay, 1996). Comorbidity of mental and physical health problems can be complex, requiring close working between mental and physical health professionals (Buckley *et al*, 1995; Rustomjee & Smith, 1996). Confronting stigma towards people with mental illness has taken on a higher profile recently with the launch of the Royal College of Psychiatrists anti-stigma campaign (Cowan & Hart, 1998). Part of the process of destigmatising mental illness is to increase the access of psychiatric patients to appropriate medical and surgical care. People with mental illnesses are often perceived as requiring less physical health care than the non-mentally ill (Dolinar, 1993). Communication of physical symptoms may be hampered by poor communication skills, and understanding of physical disease impaired. Mental health units are often sited away from medical and surgical units, leading to marginalisation of psychiatric patients and staff. This can lead to inequitable access of mental health patients to physical health services. One way to overcome this inequity would be to integrate medical and surgical liaison services for mental health patients with developments in psychiatric liaison services for medical and surgical patients. To determine whether such an integration would be feasible, a survey was undertaken of medical, surgical and psychiatric consultants asking about their attitudes to the development of a reciprocal liaison service.

The study

All medical and surgical consultants were identified in a large district general hospital serving a town on the south coast of England with a population of 160 000 people. Additionally, all consultants in the local mental health service covering a large proportion of the same population were identified. Those identified were then sent a questionnaire. Each respondent was first asked to signify the speciality in which they worked, along with an estimate of how many of their patients might require a liaison service.

Respondents were then asked to complete two sections, the first containing components of a psychiatric liaison service for medical and surgical patients and the second section, components of a physical health liaison service for mental health patients. Respondents were

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