Trainee psychiatrists’ views about their supervisors and supervision

Anna Chur-Hansen and Steve McLean

Objective: Supervision is fundamental to the trainee experience in psychiatry, but few researchers have considered this in a systematic way. In this paper, we explore trainees’ perceptions of the supervisor–trainee relationship and the supervision process. This is the first of two papers, with the second focussing on supervisors’ perceptions of supervision and trainees.

Method: Fifteen trainees were interviewed and the resultant data subjected to qualitative analysis.

Results: Trainees described the characteristics of a ‘good’ supervisor, as well as what they considered to be evident in a ‘poor’ supervisor.

Conclusions: The results of this study would be useful in designing training programs for both experienced and novice supervisors. Future research is needed to evaluate the efficacy of such training programs, as currently very little investigation into postgraduate clinical supervision has been undertaken.

Key words: medical education, psychiatry, supervision, supervisor, trainee, training.

Clinical psychiatry is primarily taught in an apprenticeship model, supported by the close and personal supervision of a qualified consultant. Yet the methods and manner of supervision are possibly the least researched areas in medical education. To our knowledge, only three Australian studies have attempted to systematically gain insight into how trainee psychiatrists perceive their supervision. In this qualitative study, we explore the role of the supervisor as seen by a group of trainee psychiatrists. Our aim was to find out what the consumers of supervision believed were the desirable and less desirable characteristics of a supervisor and the supervisory process.

METHOD

The University of Adelaide Human Ethics Committee granted approval for this study. The South Australian Psychiatry Training Committee (SAPTC) provided the first author with a list of all supervisors and trainees (from Year 1 to Advanced Trainees) in one geographical region of Adelaide. Efforts were made to telephone the 24 trainees listed, to arrange an interview with the first author about the process of postgraduate psychiatry assessment and supervision. Interviews were conducted at the University of Adelaide Discipline of Psychiatry at the Royal Adelaide Hospital, or the individual’s workplace, or at a coffee shop, as preferred by the trainee.

Interviews were semi-structured, with open-ended questions posed about supervision, including methods of supervision and assessment. Set questions included the broad opening, ‘can you tell me about your supervision experiences as a trainee psychiatrist?’, which was then followed by prompt...
questions about the supervisor–trainee relationship. Interviews were audio-taped with the trainee’s permission. Trainees were assured that confidentiality would be maintained, and that their responses would remain anonymous to the second author (the Director of the SAPTC), who would be shown thematic results and interview extracts, but not raw data from complete interviews.

The first author transcribed interviews, removing any identifying material. Data were then subjected to a modified framework analysis. This process involved immersion in the raw data, through listening to the interviews, and reading and re-reading the transcripts until familiarity with the data was achieved. Second, key thematic issues and concepts within the interview data were identified. Numerous facets of the supervision process were explored during interviews. In this paper, we report on trainee responses on the role of the supervisor, including what defines excellence in supervision, and what is deemed poor or unacceptable practice. Findings regarding the views of these trainees’ supervisors about their role are reported in a second paper.

RESULTS

Fifteen of the 24 trainees were interviewed. Two refused to participate (too busy), one was on leave, one did not return telephone calls and five agreed to be interviewed but could not find a mutually suitable time. Interviews ranged from 27 minutes to 80 minutes, with a mean of approximately 49 minutes.

What trainees define as a ‘good’ supervisor

Trainees were asked to reflect upon the qualities they identified in supervisors they thought were ‘good’. Trainees’ perceptions of their supervisors were divided into the educative, supportive and managerial roles identified by Rose and Boyce. According to this concept, the educative role involves developing technical and interpersonal skills and understanding of knowledge – in other words, the role of teacher. The supportive role comprises examining and managing the effects of training upon the learner, and the managerial role refers to quality control and ensuring that work practices are appropriate and fall within expected standards. It should be noted that these three role divisions are overlapping and not necessarily discrete. For example, to be an effective teacher one may also ideally provide appropriate support and role model ethical managerial skills.

The characteristics of a good educating supervisor as identified by the trainees were: a teacher who is a role model, and who maintains the trainee (student)–supervisor (teacher) hierarchy. A good educating supervisor explains and answers questions if the trainee does not understand, and provides the reasoning behind their clinical decision making, expecting the trainee to be able to explain the reasons behind their own decisions. They allow the trainee autonomy and independence, but with ‘a watchful eye’. Supervision goals are negotiated with the trainee. The supervisor is clear about what is expected and what is to be achieved in supervision, and keeps the trainee ‘on track’ in supervision. Regular, continuous, constructive feedback on performance is provided, including criticism, in a respectful and professional manner. Relevant clinical and personal experiences are related to the trainee in an appropriate way that facilitates learning, and keeps the trainee’s mind open to intellectual challenge and new and different ways of thinking. Preparing trainees for examinations was considered important. Also seen as important was being clinically up-to-date and competent, being abreast of the research literature and engaging in continuing professional education. A good supervisor was seen to place clinical issues into wider contexts, such as social, political and historical. They ensure the trainee has frequent and varied experiences, monitoring areas of need in training and ensuring that these are addressed. Theory is linked with practice and trainees are provided with relevant readings and educational material.

A supportive supervisor was seen by trainees to be a mentor, who cares about the trainee and about supervision. They are maternal or paternal, particularly during the early years of training, and listen to trainees when they are having problems related to clinical practice. They are supportive and empathic when the trainee experiences work-related stress, including coping with adverse patient outcomes, such as suicide. A good supportive supervisor is able to tell the trainee if they should not pursue a career in psychiatry, in a sensitive way. He or she counsels the trainee, but never tries to engage in therapy with them. They are respectful of the trainee and expect similar respect to be returned; they ideally have rapport with the trainee, but are tolerant and flexible when there is a personality clash. Adjectives used to describe a good supervisor were ‘honest’, ‘flexible’, ‘understanding’, ‘approachable’ and ‘accessible’.

A good managerial supervisor works closely with the trainee on the ward, is ‘hands on’ with the patients, takes responsibility for clinical decisions made by the trainee, is aware of SAPTC and College training requirements, understands the mental health system and the political processes that impact upon psychiatry, and provides clinical leadership.

While acknowledging that a good supervisor can be either male or female, trainees expressed a preference for younger, more recently qualified supervisors. They noted that with these supervisors the status hierarchy was weaker, meaning they feel more comfortable, and that these supervisors often had a better knowledge of the supervision process and requirements.
What trainees define as a ‘poor’ supervisor

Trainees were similarly asked to reflect upon the supervisors they felt to be ‘poor’. Their responses can also be delineated into educative, supportive and managerial roles.

Trainees felt that a poor educating supervisor might be recognized by incompetence as a psychiatrist, with poor or out-of-date clinical skills. Little clinical guidance is given, and the supervisor places too much responsibility on the trainee too early, and allows the trainee to perform unfamiliar procedures, such as electroconvulsive therapy, without supervision. A poor supervisor, in the educative sense, rarely sees the trainee and does not attend scheduled supervision sessions, gives no structure to supervision sessions and treats supervision as a chore to be endured. Praise and positive feedback is given, with no direction for improvement, or the supervisor indicates there is a problem, but gives no guidance about how to solve it or what should be done.

Registrars identified a supervisor’s poor supportive skills as including losing their temper with the trainee and shouting and being abusive, with no warmth in their interpersonal interactions with the trainee. Also discussed was intolerance of trainees with psychological disorder, emotional distress or psychiatric illness, intimidation, finding fault repeatedly, making the trainee anxious and fearful, and making judgements about the trainee based on discrimination, including sexual, racial or regarding the trainee’s mental health. A poor supervisor wishes to engage with the trainee in psychotherapy and attempts to ‘psychoanalyse’ the trainee. Derogatory comments are made about the trainee, both to the trainee and to others. The trainee feels uncomfortable during interactions, due to inappropriate behaviour, including sexual innuendo and harassment. The supervisor refuses to discuss any self-doubt the trainee may have about being a psychiatrist, and will not discuss career options. The supervisor is ‘fixed’, ‘rigid’, a ‘perfectionist’ and ‘eccentric’.

A supervisor seen as not being a good manager is rarely on the ward, unaware of training requirements and politically out-of-date.

DISCUSSION

The desirable and less desirable characteristics of supervisors and of the supervisory process from the trainees’ point of view is wide ranging and raises some important considerations.

Consistent with the findings of Clarke,\(^3\) and Koslowska et al.,\(^4,5\) trainees were clear about their need for effective teaching and support. While supervisors’ clinical competence was seen as important, a greater emphasis was placed on teaching skills and supportive behaviour. Supervisors’ managerial skills were mentioned far less often as an important aspect of their competence. This finding is at odds with that of Koslowska et al.,\(^4\) who found that trainees valued a supervisor’s clinical competence more highly than their emotional supportiveness. It is possible that our finding emerged because of the qualitative nature of the data collection. We did not ask specifically about clinician competence or supportiveness or teaching, but allowed the trainees to articulate what they saw as of greatest relevance. The fact that trainees discuss teaching and interpersonal skills more than clinical or managerial skills in evaluating a ‘good’ supervisor is an important finding.

The issue of training supervisors has been considered by a number of authors.\(^1-5,8\) To date, however, a full curriculum for training in Australia has not been proposed, although Cottrell from the United Kingdom proposes the content of a training programme that includes material on adult learning theories, formative and summative assessment and how to design the content and structure of supervision.\(^8\)

Kilminister and Jolly reviewed the literature on supervision in clinical settings across all healthcare professions, including medicine, nursing, social work and psychology.\(^9\) They conclude that there are no theoretical models of supervision in existence to guide the design of training interventions for supervisors. Kilminister et al. propose a framework for effective training for supervisors, which encompasses “basic teaching skills, facilitation skills, negotiation and assertiveness skills, counselling and appraisal skills, mentoring skills, knowledge of learning resources and certification requirements” (p. 385).\(^1\) This framework would seem a sensible one that could be used by the RANZCP in designing a bi-national training program for supervisor training.

Certainly, in a supervisor training programme we would see the list of characteristics produced by this research as valuable in giving structure to the role of the supervisor, as well as encouraging reflective practice for supervisors, who could consider whether they might be deemed ‘good’ or otherwise. From that point, specific training could be directed at areas of perceived weakness.

This research is unusual in that it is qualitative. There are a number of questions that derive from it that require further study, and these could be explored using both qualitative and quantitative designs. Our study is, like previous research, cross-sectional in its nature. With so little known and understood about supervision for trainee psychiatrists, possible areas for future research include an investigation of the process of learning to be a supervisor, using a longitudinal study, as well as the long-term influences of supervision on trainees, including their clinical practice.\(^7\) Of paramount importance is research to establish whether training supervisors improves the supervisory process, and if so, in what ways.
ACKNOWLEDGEMENTS

The authors are grateful to the late Professor Rob Barrett, who suggested that this research be conducted. We would also like to thank Dr Mary Frost, Dr Taryn Cowain and Dr Shane Gill for helpful suggestions during the formulation of the research, and to the South Australian Psychiatry Training Committee (SAPTC) who funded a digital tape recorder for the first author’s use for the project. Finally, we are indebted to the trainees and supervisors who were generous in both the time they gave and the candid thoughts they shared.

REFERENCES
