

Supervision for superheroes: the case for reflective professional supervision for senior doctors

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ABSTRACT

The practice of medicine is inherently stressful with regular exposure to trauma and the distress of others. There is a culture in medicine that doctors should not be affected by such things, although it is well recognised that doctors have higher rates of depression, anxiety, suicide, and substance abuse than the general public. Reflective professional supervision is a forum where the complexities of the interpersonal interactions that underpin the provision of healthcare can be explored in a supportive and confidential setting. It is argued that this is a process that should continue for the duration of a doctor's career, with potential benefits including enhanced job satisfaction and resilience, better workplace communication and improved interpersonal skills.

Professional supervision is a process that is not well understood, and is under-utilised by those in the medical profession, especially among those in the hospital-based specialties. Colleagues in other helping professions have a long history of engaging in professional supervision, and for disciplines such as social work and psychology, attendance at supervision is mandatory to maintain registration. Other helping professionals (eg, school principals, church ministers, probation officers) are now also beginning to utilise supervision, so why not doctors?

It would seem that among doctors there is a lack of understanding as to what reflective professional supervision entails. There are many different types of supervision with different functions and formats and some confusing terminology. The supervision with which most doctors are familiar from their years in training tends to be hierarchical in nature, and focused on the technical and educational aspects of medicine, with functions of oversight and assessment. This form of supervision is a requirement for junior doctors, but once specialist qualifications are obtained it often comes to an end.

There is a common misperception that supervision is only for those who are still in training, or for those who are somehow lacking or incompetent. To the contrary, a willingness to engage in supervision and explore vulnerabilities requires strength, maturity and commitment.

Senior doctors may engage in peer review, but that again tends to focus on the technical aspects of health care, with little emphasis on the emotional impact of medicine. The environment of peer review may also be competitive due to the personality types that medicine can attract, and is often not conducive to exposing vulnerabilities.

Medicine can be a rewarding career, but it is also inherently challenging and stressful. The higher rates of depression, anxiety, substance abuse and suicide amongst doctors compared to the general population are well recognised by the profession, as noted in the New Zealand Medical Association position statement on *Doctor's Health, Wellbeing and Vitality*.¹ Doctors are exposed to a number of stressors, including heavy workloads, long hours, limited resources, time and administrative pressures, high expectations, public accountability and the risk of complaint. Doctors across the range

of specialties are also exposed to the pain, distress, trauma and suffering of patients and their families on a daily basis. This can have a cumulative effect on medical professionals known as vicarious trauma or secondary traumatic stress, an experience that many doctors may be aware of, but may not be able to name. Vicarious trauma was first described in 1990 by Pearlman and McCann² and refers to the changes in cognition, perception and world view that can arise as a result of repeated exposure to the distress and suffering of others. If not recognised and managed appropriately with the use of processes such as professional supervision, the cumulative effects of stress and exposure to trauma may impact upon practice, and may adversely affect relationships with colleagues, patients, partners and families.

So what is professional supervision? Supervision is a process that provides the opportunity for reflective practice. It is a confidential space in which to step back, or take a pause from practice to reflect upon work-related issues and the impact that they may be having on the individual, either personally or professionally. It can also be a place to reflect upon the values and passion that lead to a career in medicine and to ensure that these things have not been forgotten or subsumed. Procter described the functions of professional supervision as formative (ie, professional development), normative (ie, administrative) and restorative (ie, supportive).³

Supervision may be provided from within an organisation or by an external provider. Supervision may be conducted by peers or by a professional from another discipline. A model of peer supervision may be more acceptable to doctors, but it is imperative that the supervisor (whatever their discipline) receives appropriate training in the provision of supervision. One of the key elements for effective supervision is the relationship that develops between the supervisor and the supervisee, which should be characterised by trust, openness and honesty.

Supervision should be a structured process that is collaborative in nature, and typically involves meeting for an hour once a month. The supervisee is encouraged to bring topics for discussions that are

then explored in some detail. These may include difficult interactions with patients or families, conflict with colleagues or junior staff or organisational issues. Ethical dilemmas may be explored, as may situations where things have gone well. While it is important that supervision does not turn in to counselling, personal issues that are impacting on work performance can be discussed, as can the impact that work situations may have on home and family life.

Supervision can utilise a range of different models. Dr David Owen, chair of the professionalism advisory group in the Faculty of Medicine at the University of Southampton, has described “The Five Realms” as a model for supervision in the medical profession.⁴ This looks at all aspects of the clinical relationship, with the five realms being the realm of the illness, the realm of the patient (and their family), the realm of the doctor (including aspects of the doctor’s relationship with the patient and their colleagues, their work and home environment and their personal well-being), the realm of the supervisory relationship (eg, patterns which emerge in supervision may reflect general patterns of interactional style), and the realm of the organisation or cultural context in which practice occurs. This model enables a broad exploration of different aspects of the doctor’s work from a range of varying perspectives. A feature of good quality supervision, as noted by The London Deanery,⁵ is that aspects of the supervisory relationship can mirror aspects of the doctor/patient relationship. Skills and attributes that contribute to effective supervision may be similar to those that characterise effective patient consultations (eg, curiosity, compassion, honesty, thoughtfulness, respect and collaboration).

So what are the likely barriers that may prevent doctors from engaging in professional supervision? Unfortunately, stigma is likely to be a significant factor. In spite of public education campaigns aimed at destigmatising mental health issues, such as Like Minds, within the medical profession and the wider community, there remains significant stigma towards mental health issues and the discomfort that doctors have in seeking help is well recognised.⁶ In order for doctors to begin to acknowledge that they may be vulnerable to the stress and emotional load

of providing health care, there would need to be a major cultural shift within the medical profession. Education on vicarious trauma and the need for self-care/self-awareness needs to be emphasised from very early on in the doctor's career, and initiatives such as Year 6 medical student mentoring would seem to be a step in the right direction.

Another potential barrier is the perception among doctors that as professionals we are superhuman and somehow immune to the adverse effects of exposure to trauma and distress. In the same way that the recent Association of Salaried Medical Specialists (ASMS) survey found high rates of presenteeism, with "superhero" doctors turning up for work even when unwell, there is a widespread view that doctors should not be emotionally or psychologically impacted upon by the nature of their work.⁷ Keeping a "professional distance" somehow acts as an invisible protective cloak for the superhero doctor. Exposing weakness or vulnerability may be viewed negatively, with fears that this may impact upon career progression or registration. Many clinicians refer to being able to box things away, or compartmentalise, but over time things tend to seep between these artificially constructed compartments, or else express themselves in other negative ways, such as substance abuse.

Lack of organisational support may be another barrier, and the widespread implementation of professional supervision among the medical profession would be a substantial cost in terms of both money and time for supervisor and supervisee. However, under health and safety legislation there is a requirement for employers to address workplace stress. If an employer does not adequately address workplace stress, then they may face legal action under the Health and Safety in Employment Act 1992.⁸ Encouragement of the use of professional supervision at an organisational level could be viewed as a proactive approach to managing and protecting staff wellbeing. This is beginning to be recognised in the legal profession, another group with high rates of mental health and substance abuse issues. In Australia, the County Court of Victoria has introduced the Supporting Judicial Resilience Program, a pilot program that provides judges with

regular professional supervision in recognition of the potential negative effects of stress and exposure to traumatic material.⁹

It may be argued that professional supervision is a process that should continue for the duration of a doctor's career. Over time, the primary focus of supervision may change from dealing primarily with clinical issues, to exploring the more subtle and complex nature of interpersonal interactions that are inherent in all areas of medicine. Communication issues are at the heart of many complaints involving clinical care and often contribute to difficulties within the multi-disciplinary team. Bullying in the workplace, as reported by the Resident Doctor's Association,¹⁰ is a serious issue that the profession needs to address, and is reflective of problematic interpersonal relationships. Exploring difficult interactions in detail in a safe supervisory relationship may help cast a different perspective on challenging situations and alternative actions and responses may be formulated.

In terms of the evidence base, while professional supervision would intuitively seem to be a helpful process, it does need to be acknowledged that this is an area that requires further well-conducted studies. There have been a large number of studies published, mainly within the nursing and allied health professions, but there are difficulties defining supervision and controlling for the content, process and quality of supervision. Difficulties also arise in determining and measuring appropriate outcomes. A recently published Cochrane Review reported on a systematic review of the literature that looked at the impact of clinical supervision on counsellors and therapists, their practice and their clients. The authors concluded,

"supervision appeared to have a positive impact on therapist self-awareness, skills, self-efficacy, theoretical orientation, support and to some extent outcomes for clients, but the quality of the data was variable".¹¹

Very few studies have been identified which explore the role of professional supervision in doctors, which is likely to reflect the limited uptake of supervision by the medical profession, and this is clearly

an area that requires further research. A structured pilot programme to evaluate the impact of professional supervision on a group of doctors may be helpful in terms of progressing the argument for more widespread use of this process.

The role of regular professional supervision for all doctors is worthy of further consideration, and measures to enhance doctor's wellbeing and resilience should be prioritised. A willingness by senior doctors to reflect on practice and to expose their vulnerabilities by engaging in professional

supervision would set a positive example to our junior medical colleagues, and to other members of the multi-disciplinary team. By becoming more compassionate towards ourselves, we can become more compassionate towards our patients, our co-workers and our junior doctors. A better understanding of the subtleties and complexities of the interpersonal interactions involved in the provision of health care may also help put the patient back at the centre of clinical care and may help re-establish some of the art of medicine.

Competing interests:

Helen Austin reports to have a small private practice offering professional supervision to others professionals.

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