# Clinical supervision by consultants in teaching hospitals

Craig T Hore, William Lancashire and Robert G Fassett

## ABSTRACT

- Clinical supervision is a vital part of postgraduate medical education. Without it, trainees may not learn effectively from their experiences; this may lead to acceptance by registrars and junior doctors of lower standards of care.
- Currently, supervision is provided by consultants to registrars and junior doctors, and by registrars to junior doctors.
- Evidence suggests that the clinical supervision provided to postgraduate doctors is inadequate.
- Registrars and juniors doctors have the right to expect supervision in the workplace.
- Impediments to the provision of clinical supervision include competing demands of hospital service provision on trainees and supervisors, lack of clarity of job descriptions, private versus public commitments of supervisors and lack of interest.
- Supervisors should be trained in the process of supervision and provided with the time and resources to conduct it. Those being supervised should be provided with clear expectations of the process.
- We need to create and develop systems, environments and cultures that support high standards of conduct and effective clinical supervision. These systems must ensure the right to supervision, feedback, support, decent working conditions and respect for both trainees and their supervisors.

MJA 2009; 191: 220–222

For editorial comment, see page 196

Surveys in the United Kingdom have found that clinical supervision is inadequate,[1] and the situation is almost certainly similar in Australia. A resident medical officer at our hospital recently asked why, after hours, the most inexperienced doctor in the hospital was called first to review a sick patient. He opined that he did not have the experience, applied knowledge or skills to appropriately identify and assess critically ill patients.

Unfortunately, this may be a common scenario in Australian hospitals. For example, although most universities include exposure to intensive care medicine in their curricula, in a recent survey of intensive care trainees, only 19% recalled their first intensive care unit exposure being at undergraduate level.[2] Indeed, 23% had no exposure until registrar level.[2]

Patients with serious medical conditions are more likely to die in hospital if they are admitted on a weekend compared with a weekday.[3] As hospitals are complex systems, this finding cannot be attributable to one factor, but the effectiveness of clinical supervision is likely to be a contributing factor. To demand perfect human performance in a complex system like health care, without providing appropriate support, is to expect performance beyond human capability.[4,5] There is evidence that supervision has a positive effect on patient outcome, and that lack of supervision is harmful for patients.[1] Hence, inadequate training and supervision can be contributing factors to serious adverse events. Most doctors can recall incidents from their clinical training that had profound effects on their subsequent medical practice.

### What is clinical supervision?

Clinical supervision in current practice has little empirical or theoretical basis.[1] Even the definition of supervision in medicine lacks consistency and is often assumed.[6] The views of supervisors may be different from those of trainees (those doctors enrolled in a specific training program).[6] Most would agree that supervision has an educational element, but it is more than just acquisition of knowledge.[1,6] It also comprises evolution of confidence, competence and personal growth.[6] Other basic functions are administrative and supportive.[1] Supervision also occurs in many settings, for example, on the work floor, as a one-on-one meeting, in a group (with or without a facilitator), or with peers.[1] One proposed definition of supervision in medicine that encompasses these various elements is "the provision of monitoring, guidance and feedback on matters of personal, professional and educational development in the context of the doctor's care of patients".[1]

### What are the benefits of effective clinical supervision by consultants?

Clinical supervision is a vital part of quality postgraduate medical education. Without it, trainees may not learn effectively from their experiences.[7,8] The supervisory needs of trainees will vary according to their experience and level of training.[1] Unsupervised experience may lead to acceptance by registrars and junior doctors (interns and residents) of lower standards of care.[1] Without specific guidelines, trainees may not see a representative variety of patients or be exposed to a necessary variety of procedures.[9] On the other hand, trainees report benefits from effective supervision in terms of confidence, professional identity, therapeutic knowledge, critical thinking, intervention, positive anticipation (the ability to look forward to and plan events in a positive way), recognition of personal issues, and feeling valued and respected.[1]

### What are the existing impediments to clinical supervision by consultants?

Firstly, who does the supervision? The focus of our article is on supervision by consultants, yet it is acknowledged that for interns and residents, most direct clinical supervision is by registrars.[10] Registrars, however, are also learning and require supervision themselves.

Trainees should expect a right to supervision, feedback, support, decent working conditions and respect.[6] The same should also apply to their supervisors. But there are impediments. For example, some trainees resist change, lack insight or display other defensive behaviour that can have a negative effect on the supervision process.[1] Other impediments for trainees include a hospital system that appears to support provision of service over training,

**1 Suggested responsibilities of clinical supervisors**

- Provision of direct guidance on clinical work.[1]
- Participation in specific supervision training courses, skills maintenance programs and accreditation procedures, such as those offered by the relevant specialist Colleges.[1,6,15]
- Provision of advice, feedback and reassurance to trainees.[1]
- Development of a strong supervision relationship, including being a positive role model.[1]
- Provision of adequate periods of uninterrupted supervision of trainees in terms of physical proximity and clinical time.[1,6,11]
- Educational supervision and direction ("directed self-learning") including assistance for trainees with linking theory and practice, and joint problem-solving exercises with trainees.[1] ◆

**2 Suggested features of a supervision program**

- Structure (eg, ground rules and learning objectives) with flexibility.[1] What is suitable for one specialty may not be suitable for another.[7]
- Broad content, including: clinical management, teaching and research, examination preparation, management and administration, pastoral care, interpersonal skills and personal development.[1]
- Job descriptions for supervisors and trainees.[11]
- Monitored supervision plans.[11]
- Trainees and supervisors well supported by managers and working well with them.[11] ◆

and the potential conflict between commitment to service as a whole and commitment to an individual patient's care.[7,11] The roles and responsibilities of the trainees may not be clear.[7] For example, in a UK audit, fewer than 60% of training-grade doctors had been given a job description.[11] As attested by trainees at our hospital, this also occurs in Australia. Another problem in some specialties is that consultants and trainees may spend much of their working time on separate sites, such as public and private hospitals.[6] At the same time, we are seeing a drive to decrease the work hours of trainees.[7,12] This is a positive step, but could also lead to a reduction in supervision and the educational value of their training.[13,14] On the other hand, high-quality training, including a closely structured and well supervised working environment, can offset these changes.[7]

For supervisors, impediments include competing interests and work pressures, an expectation to supervise regardless of interest, little or no education on effective supervision, institutional disincentives, lack of research evidence on outcomes of supervision, and simple inertia.[1,6] Training of supervisors is essential, with postgraduate medical councils and specialist Colleges now offering focused training for supervisors.

## What can be done to improve effective supervision by consultants?

Given the above impediments, there may now be fewer opportunities for a supervisor to be a role model than there were previously.[6] We believe that clinical supervision can be an Achilles heel of the hospital system. Hospitals generally lack either the resources or the motivation (or both) to ensure that it is done effectively. We need to create and develop systems, environments and cultures that support high standards of conduct and effective clinical supervision. This will require: commitment from the organisation, consultants and trainees; allocated time; and governance of the process.

Effective supervision requires the right staff. Recent publications from varying disciplines have offered suggestions for improved clinical supervision and can be used to build a framework.[6] For supervisors, suggestions include those listed in Box 1. The supervision program should include the features outlined in Box 2.

We also offer contentious suggestions that are at least worthy of reflection. What about having patients always under the on-site supervision of a consultant (a consultant-based service),[11] or at least ensuring that consultants and trainees spend as much time as possible working in proximity rather than on separate sites (eg, the consultant in private rooms or at a private hospital; the junior doctors and registrars in the public hospital). This could be achieved by locally agreed or specialty-defined guaranteed direct supervision time. If shift work is appropriate for trainees, could it also be appropriate for consultants, at least in some specialties or in some contexts?

Before acting upon these, we suggest it would be more appropriate to improve the clinical supervision that is already being provided along the lines that we have indicated. Finally, it needs to be remembered that although behavioural changes can occur relatively quickly as a result of supervision, definitive changes in thinking and attitude may take longer.[1] However, the benefits for hospitals, patients, trainees and supervisors will be worth the persistence.

## Conclusion

Supervision should have structure, with ground rules and learning objectives, yet flexibility. What is suitable for one specialty may not be suitable for another. One of the most important factors is the supervision relationship. Consultants should act as role models, but it is not a one-way street — trainees need to have some control over, and input into, the process. Finally, the system within which the supervision is provided must ensure the right to supervision, feedback, support, decent working conditions and respect for both trainees and their supervisors.

## Competing interests

None identified.

## Author details

**Craig T Hore,** MB BS, FACEM, FJFICM, Intensive Care Specialist[1]
**William Lancashire,** MB BS, FRACGP, CCFP, Director of Critical Care[1]
**Robert G Fassett,** MB BS, PhD, FRACP, Director of Renal Research[2]
1 Port Macquarie Base Hospital, Port Macquarie, NSW.
2 Royal Brisbane and Women's Hospital, Brisbane, QLD.
*Correspondence:* craig.hore@ncahs.health.nsw.gov.au

## References

1 Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: a literature review. *Med Educ* 2000; 34: 827-840.
2 Stachowski E, Fugaccia E. Who wants to be an intensivist? *ANZCA Bull* 2004; 13: 58-59.
3 Bell CM, Redelmeier DA. Mortality among patients admitted to hospitals on weekends as compared with weekdays. *N Engl J Med* 2001; 345: 663-668.

4 Wolff AM, Bourke J. Reducing medical errors: a practical guide. *Med J Aust* 2000; 173: 247-251.
5 Leape LL. Error in medicine. *JAMA* 1994; 272: 1851-1857.
6 MacDonald J. Clinical supervision: a review of underlying concepts and developments. *Aust N Z J Psychiatry* 2002; 36: 92-98.
7 Scallan S. Education and the working patterns of junior doctors in the UK: a review of the literature. *Med Educ* 2003; 37: 907-912.
8 Marteau TM, Wynne G, Kaye W, Evans TR. Resuscitation: experience without feedback increases confidence but not skill. *BMJ* 1990; 300: 849-850.
9 Coates WC, Gendy MS, Gill AM. Emergency medicine subinternship: can we provide a standard clinical experience? *Acad Emerg Med* 2003; 10: 1138-1141.
10 Lack CS, Cartmill JA. Working with registrars: a qualitative study of interns' perceptions and experiences. *Med J Aust* 2005; 182: 70-72.
11 Jackson P. Hospital doctors' work. *BMJ* 1995; 310: 952-953.
12 Australian Medical Association. National code of practice: hours of work, shiftwork and rostering for hospital doctors. Canberra: AMA, 2005.
13 Bourne MC, Paterson-Brown S. Calman and the new deal — compromising doctor training and patient care. *Scott Med J* 1999; 44: 147-148.
14 Kelty C, Duffy J, Cooper G. Out-of-hours work in cardiothoracic surgery: implications of the New Deal and Calman for training. *Postgrad Med J* 1999; 75: 351-352.
15 Hillman KM. Reducing preventable deaths and containing costs: the expanding role of intensive care medicine. *Med J Aust* 1996; 164: 308-309.

*(Received 3 Feb 2009, accepted 27 Apr 2009)* ❑