Supervision of trainees

Peter Herriot, Kamaldeep Bhui and Paul Lelliott

The Royal College of Psychiatrists specifies that supervision of trainees is the single most important ingredient of training. This paper reports the results of a pre-audit survey about trainee supervision. Eighty-three per cent of consultants (*n*=52) and 67% of trainees (*n*=51) responded to a 21-item Likert questionnaire. There was unanimous agreement for seven items. A significant number of consultants and trainees were dissatisfied with the existing arrangements despite the majority being involved in weekly supervision. The minimum standards proposed served as the basis for providing guidelines against which practice may be audited.

The Royal College of Psychiatrists offers few specific guidelines on the structure, and even fewer on the content, of supervision by consultants of their trainees.

The statement on Approval of Training Schemes for General Professional Training (Royal College of Psychiatrists, 1992) emphasises that supervision is the "single most important ingredient of training" and states that supervision should take place individually or in small groups and that it should always be consultant led. Supervision by senior registrars alone is not regarded as adequate. Supervision should be weekly for one hour and new out-patients, as well as follow-up patients, should be presented to the consultant. The College statement also suggests that supervision could contain research for senior trainees and that if patients are discussed this should be for the purpose of training and not supervision of clinical management. The content of supervision will depend on the trainee's needs, but some suggestions are given for topics: principles of prescribing, elementary skills in counselling and psychotherapy, the Mental Health Act and relationships with other disciplines. clinical skills should be emphasised and not theoretical learning.

The Royal Australian and New Zealand College of Psychiatrists (1992), although equally imprecise on content, has stricter and more specific criteria on structure and process: supervision should be provided for not less than four hours per week for not less than 40 weeks in each year of training. At least one of these four hours should be individual supervision. Only specified and approved supervisors may supervise within a training agreement and supervision should be scheduled. There is also an emphasis on trainees observing consultants in diagnostic and therapeutic interviews and on trainees themselves being observed interviewing.

The importance that junior doctors attach to the quality of supervision they receive was highlighted during a recent exercise where trainees on the UMDS scheme were asked to suggest topics for audit and rate them in order of priority. Audit of supervision was rated by them as more important to their practice than audit of many specific clinical issues including suicide and violent incidents. In response to this, two of the authors (PH and KB) decided to conduct such an audit. In the absence of specific guidelines, and initial 'pre-audit' survey was conducted to ascertain views as to what constitutes good supervision, as well as to determine current practice.

The survey

A 21-item questionnaire was sent to all consultants and trainees in four health authorities comprising the UMDS psychiatric training scheme: Bexley, Greenwich, Lewisham and North Southwark, and West Lambeth. Fifty-two consultants and 51 trainees were surveyed. Responses were received from 43 consultants (83%) and 34 trainees (67%). The questionnaire items (all but two presented as five point Likert scales) covered the following areas:

(a) whether supervision was occurring and the level of satisfaction with it
(b) when applicable, reasons why it was not occurring
(c) which issues and topics should be covered during supervision?

Findings

What should supervision involve?

There was unanimous agreement among both consultants and trainees about seven items relating to what supervision should ideally involve.

(a) Every trainee should receive one hour of individual consultant supervision per week.
(b) Presentation of one new out-patient per week does not suffice as adequate supervision.

https://doi.org/10.1192/pb.18.8.474 Published online by Cambridge University Press

Table 1. Responses of consultants and trainees to items relating to the structure and content of supervision

		Agree	Neutral	Disagree
		%	%	%
Supervision by a senior registrar is adequate	Consultants	5 (12)	6 (14)	32 (74)
	Trainees	11 (32)	6 (18)	17 (50)
Trainees can be adequately supervised in small groups of two or three	Consultants	14 (33)	7 (16)	22 (51)
	Trainees	11 (32)	10 (30)	13 (38)
There should be an agreed agenda of topics	Consultants	20 (46)	15 (35)	8 (19)
	Trainees	18 (53)	9 (26)	7 (21)
supervision should include:				
more academic training	Consultants	18 (42)	16 (37)	9 (21)
	Trainees	19 (56)	6 (18)	9 (26)
more case presentations	Consultants	29 (67)	8 (19)	6 (14)
	Trainees	23 (68)	10 (29)	1 (3)
exam oriented material	Consultants	15 (35)	19 (44)	9 (21)
	Trainees	19 (56)	11 (32)	4 (12)
discussion of journal papers	Consultants	16 (37)	16 (37)	11 (26)
	Trainees	12 (35)	15 (44)	7 (21)
discussion of potential research projects	Consultants	39 (91)	4 (9)	0 (0)
	Trainees	25 (74)	9 (26)	0 (0)
watching the consultant interview patients	Consultants	22 (51)	7 (16)	14 (33)
	Trainees	17 (50)	8 (24)	9 (26)
reviewing the quality of case-note entries	Consultants	36 (84)	5 (12)	2 (4)
	Trainees	15 (44)	13 (38)	6 (18)
career advice	Consultants	36 (84)	6 (14)	1 (2)
	Trainees	25 (74)	8 (24)	1 (3)

(c) Supervision in a ward-round or outpatient department does not suffice as adequate supervision.
(d) Individual supervision is still necessary even if informal advice can be sought during the week.
(e) Individual supervision is still necessary for experienced senior house officers and registrars.
(f) Supervision should be planned in advance.
(g) Supervision is an important source of support for the trainee.

Table 1 lists 11 other items relating to the structure and content of supervision. There was considerable support, and agreement between consultants and trainees, that supervision should include discussion of potential research projects, presentation of clinical cases and the imparting of career advice. There was a lack of enthusiasm for supervision being conducted by senior registrars or in small groups. The only major point of disagreement was in the degree of importance placed, by consultants, on reviewing the quality of case-note entries.

Existing practice

About three-quarters of trainees (n=26) were receiving, and three-quarters of consultants (n=33) were providing, weekly supervision. Significant numbers of both consultants and trainees reported that they were not fully satisfied with either the current level of individual supervision (23% [n=10] and 26% [n=9] respectively) or general supervision in the posts (16% [n=7] and 26% [n=9] respectively).

Comment

The significant numbers of both consultants and trainees failing to express satisfaction with current supervision practice indicates room for improvement.

Davies (1993a) has advocated a 'trainees' charter' listing the obligations of training posts to their trainees. An alternative, or perhaps complementary suggestion, is that each training scheme establishes their own guidelines as to what constitutes good training and that trainees take a lead in auditing practice against these guidelines (Davies, 1993b). This has the advantage of both providing a mechanism for monitoring of the quality of supervision (in addition to infrequent accreditation visits) as well as involving trainees in an audit project that can follow them as they rotate around the posts in a scheme.

This survey may provide a basis for developing such supervision guidelines. It shows wide

https://doi.org/10.1192/pb.18.8.474 Published online by Cambridge University Press

agreement on the importance of individual consultant supervision and provides indicators as to content; this in accord with College guidelines. Career advice, discussion of research, case presentations and interview skills were all considered important and the inclusion of these either as a result of local agreement or through more explicit guidelines from the College, may lead to the development of the optimal programmes of supervision.

We propose that local scheme organisers should ensure that, as an initial minimum standard, every trainee receives a minimum of 16 hours individual supervision by his or her consultant in every six month period. This time should be timetabled and planned at the beginning of the post, with an agenda being set reflecting the individual trainee's previous experience, strengths, weaknesses and interests. Special areas of consultant expertise may also be considered a suitable focus for some supervision sessions. This supervision should be in addition to any other teaching during ward rounds or in out-patient clinics. Each of the components listed in Table 1 should be considered for inclusion in the supervision programme. It should be ensured that areas of training not covered in supervision sessions occur at other times during the week.

To be effective, audit of supervision should involve data collection, recommendations to improve practice, the setting of standards, a mechanism to encourage change and a procedure to re-evaluate practice so that higher standards can be pursued. If supervision standards are agreed for an entire training scheme then comparisons are possible between different locations. Although it is important that trainees play a central role in developing standards and monitoring the extent to which they are met, overall co-ordination of the audit may have to be by a clinical tutor with input from the local clinical audit departments.

Log-books may have a useful role in this process. Although mostly mooted as case-books, it has been previously suggested by Cole & Scott (1991) that these may form the basis for individual tutorials with trainees. Both the guidelines and audit mechanism could be incorporated into the log-book, which could then be used for recording the interaction between consultant and trainee and the trainees' progress through the training scheme.

Acknowledgements

We would like to thank Fay Croft and Debbie Pritchard of the Mental Health Information Technology Department and all the consultants and trainees at UMDS for their assistance.

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Peter Herriot, Registrar, *Department of Psychiatry, Guy's Hospital, London SE1 9RT;* Kamaldeep Bhui, *Research Fellow, UMDS, Guy's Hospital; and* Paul Lelliott, *Deputy Director, Research Unit, Royal College of Psychiatrists, 11 Grosvenor Crescent, London SW1X 7EE*