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Supervision as-usual—Is it enough?

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ABSTRACT

Objective: Supervision in most training centers in India happens routinely in all training situations and often for a group of trainees rather than in a one to one protected manner. How satisfied are trainees with the current methods of supervision? How holistic is the supervision? Are there major gaps with this method compared to formal individual time protected supervision? These were some of the questions that were addressed in this study.
Method: Satisfaction about supervision among 47 post-graduate psychiatry residents in the academic year 2009–2010 was studied. A checklist was constructed to assess satisfaction in areas of educational supervision, clinical supervision and personal/research supervision. Two sets of questions were used – one with a likert scale and the other with a true/false rating.
Results: Psychiatry residents were satisfied with most areas of supervision. Clinical supervision was superior to educational (including research) and personal supervision. Educational supervision was reported to be satisfactory, however, supervision during external postings, examination clinics and related to development of specific areas of interest, was inadequate. Low levels of satisfaction were reported with supervision regarding psychosocial management. In personal supervision, the areas of need identified were: (1) Involvement of residents in leisure activities, (2) Social and administrative skills and (3) Help in liaison with other disciplines.
Conclusions: Psychiatry residents in India were satisfied with most areas of supervision even though it is informal and as-usual (i.e. done on a need based way) in most settings. Some specific areas may require more formal and time protected supervision.

1. Introduction

Supervision is an important method by which consultant psychiatrists train their juniors to become future consultants (Cottrell, 1999). This involves active monitoring of the post graduate trainee in various aspects of residency (Robertson and Dean, 1997). The quality of supervision has been found to be one of the key items in determining the satisfaction with residency training programs (Ellencweig et al., 2009). Supervision should ideally include guidance and inputs in the following areas (Robertson and Dean, 1997): (1) clinical management, (2) teaching and research, (3) managerial and administrative skills, and (4) pastoral care. Thus, it is evident that the role of a supervisor is multifaceted. He/she is not only a clinical supervisor, but also an educational/personal/research supervisor. In addition, the psychotherapy needs of the psychiatry resident should be individually supervised.

Methods of supervision vary between countries and centers. In the United Kingdom (UK), each trainee is supposed to spend 'a protected hour per week' with his/her educational supervisor (RCP, 1998; Cottrell, 1999). In the United States of America/Canada, a resident must be provided at least 2 h per week of individual supervision in the second, third and fourth years of post graduate training (Zisook et al., 2007). In Canada, there is additional supervision to ensure basic competence in consultation liaison psychiatry, addiction psychiatry and geriatric psychiatry (Zisook et al., 2007). Thus, individual 'protected time' supervision which is regular and scheduled is the norm in these settings.

In contrast, supervision methods in India vary between centers of psychiatric training and often depend on the teacher student ratio and patient loads. 'Supervision as-usual' in India usually happens at multiple levels and in various settings. It is often informal rather than in a regular or scheduled manner. Supervision in most training centers in India also happens in a group rather than individually, publicly rather than privately, except for dissertation related supervision. This happens because of high student to teacher ratios, heavy clinical workloads, absence of research posts and the supervisors having multiple roles including training, patient care and research in addition to administrative work. Culturally too, teaching in India has focused on group and peer based learning and teaching. Also, supervisory needs are often high among Indian trainees in psychiatry due to a transition from

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undergraduate predominantly lecture based classroom learning to newer areas and forms of learning which require more supervision. Also, minimal exposure to psychiatry in under-graduates introduces new issues such as those related to patient doctor boundaries, personal emotions and the medicine–psychiatry interface.

The current study was conducted at an academic psychiatric training center, the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, India. Every academic year, 20 post-graduate psychiatric trainees enter the mainstream course as junior residents (JR) – and finish their training at the end of three years. There are 27 faculty members as potential supervisors, 17 senior residents, and six adult psychiatry units in addition to specialty units of child psychiatry, addiction psychiatry, family psychiatry and behavioral medicine. The rotation of JRs occurs every three months. In each posting, the JR is directly supervised by a senior resident (SR) and a consultant. Each SR and consultant supervises 2–3 junior residents at a time. In addition, the JRs are also provided with a research supervisor (thesis guide) and a psychotherapy supervisor. The only constant supervisors in this system are the psychotherapy supervisor and the thesis guide. All other supervisors keep changing over 3–6 months with the resident rotations. There is no clear divide between clinical and non-clinical supervision in this setting and these tend to occur together.

Clinical supervision refers to supervision aimed at monitoring clinical skills and techniques. In our center, SR led supervision happens daily and consultant led supervision occurs at least three days a week. Each resident in this system sees more than 50 cases per week in outpatient services (two days a week for each unit) and more than four new cases per week in the wards and discusses these with their supervisors. In the emergency setting, the turnover rates are high (30–40 cases per day), but each case is discussed with a supervisor (usually an SR).

Educational supervision primarily deals with theoretical aspects of psychiatry, although many of the topics discussed could have clinical/research implications. In this setting, educational supervision occurs at multiple levels – departmental presentations (seminar, journal club, case conference, exam clinics), unit level presentations (seminar, case conference), informal teaching in SR rounds and consultant rounds, external postings, departmental modules and guest lectures. Each resident gets to do departmental and unit level presentations quite frequently (at least three departmental presentations per year and at least one unit level presentation per month). These presentations are usually supervised from the preparation stage itself (usually two weeks prior to presentation), which is continued till the actual presentation. Other activities like modules, special programs and guest lectures occur once a month and are usually well attended.

Research supervision includes various aspects like framing research questions and appropriate methods to examine implementation of methods, analysis and interpretation of results, and systematic reviews/meta-analysis. This is primarily done by the thesis guide. Supervision starts with the thesis protocol and continues with periodic sessions about the progress of thesis work. Some of the interested residents also involve themselves in research with other mentors.

Personal supervision (e.g.: ethical and boundary issues, personal difficulties with certain clinical situations or patients, conflict resolution in a team setting, mental and physical health issues of residents, career paths) occurs in a need-based manner. Residents often chose a supervisor with whom they feel comfortable but this is not formalized.

Thus, it is quite evident that this system of 'supervision as-usual' is vastly different from what is practiced in Europe and the USA where there are regular/scheduled supervisory sessions with a designated supervisor for each psychiatric trainee. In a country with relatively few teachers in psychiatry and the need to train more postgraduates, we may not have the luxury of individual 'protected time' supervision for many years! At the same time it will not be acceptable to have trainees who have not had enough supervision, especially in the clinical practice of psychiatry where ethical and professional issues are quite common and are important aspects of training.

It is hence important to assess whether due to cultural and manpower reasons, informal and as–usual supervision on an as needed basis (group or individual) works as effectively as individual regular 'protected time' supervision available in centers around the world. One of the easiest ways to do this is to assess trainee satisfaction with supervision. This study reports findings from a survey assessing satisfaction about supervision among psychiatry residents in the academic year 2009–2010.

2. Method

Satisfaction about supervision was studied among 47 psychiatry residents (33 men and 14 women) in the academic year 2009–2010 after informed consent. Thirteen residents were unwilling to participate in the study – four residents were not convinced about the confidentiality, three residents did not want to be part of any research and the remaining six stated personal reasons for non-participation. A checklist with two sets of questions was constructed to assess satisfaction in various areas of supervision which included – educational supervision, clinical supervision, research supervision and personal (or pastoral) supervision. Two sets of questions were used to assess the adequacy of supervision in each area. In the first set, we used a likert scale scoring (1–4) system. A score of 1 or 2 was considered as unsatisfactory, a score of 3 as adequate supervision and a score of 4 as excellent supervision. The second set of questions consisted of true/false questions about the adequacy of supervision. Both sets of questions were preceded by a section consisting of information about the nature of the study, the definition of supervision, voluntary nature of participation and confidentiality of information. Any doubts about the checklist (Appendix I) were clarified by the primary author. The study was approved by the NIMHANS ethics committee.

Statistical analysis was conducted using the Statistical Package for Social Sciences (SPSS) version 13.0 (SPSS Inc., Chicago, IL, USA). Data was analyzed in terms of frequency percentage, and parametric statistics like mean and standard deviation were used to describe the sample characteristics. Research supervision questions were included along with educational supervision for the statistical analysis.

3. Results

The mean scores on each area and the rates of satisfaction are given in Table 1. Table 2 depicts the residents' response to selected true/false questions not previously covered in the likert scale scored questions. The mean (SD) scores for educational (and research), clinical and personal supervision were 2.69 (0.34), 2.80 (0.18) and 2.59 (0.22) respectively.

In the area of educational (and research) supervision, unit presentations (case and topic presentations), departmental seminar and informal teaching had the highest mean satisfaction scores (Table 1). In specific true/false questions about unit presentations, 89% residents felt that clinical skills supervision during unit case presentations was adequate. In comparison, only 70% identified interview skills supervision during unit case presentation as adequate. Lowest mean satisfaction scores (Table 1) were noted for supervision during external postings, examination clinics and development of specific areas of interest. In true/false questions, it