Original Research Paper

Self-care for GPs: the role of supervision

Hamish Wilson is a senior lecturer in the Department of General Practice in the Dunedin School of Medicine, University of Otago

ABSTRACT

Aim: To explore the experience of GPs who currently use supervision as their main method of self-care and professional maintenance.

Method: Qualitative method of in-depth interviews, followed by a focus group.

Setting: Urban and rural general practice in New Zealand.

Participants: GPs who see a supervisor on a regular basis to discuss their work.

Results: New Zealand GPs in this study used a variety of methods of professional maintenance, including supervision or "educative mentoring". Participants used supervision to review their "difficult" patients, and as general back-up for the interpersonal work of clinical practice. Supervision was also a useful method of learning counselling skills, as it helped them attend equally to patients' psychological and physical manifestations of disease. Studying these successful relationships gave insights into the barriers that prevent further utilisation of supervision or other forms of mentoring in general practice. The data analysis led to a definition of supervision in general practice.

Conclusions: Having supervision appeared to have a positive impact on the participants' style and philosophy of practice. It helped to counter the stresses of long term work as a helping professional by providing a dedicated forum for work appraisal and self-care. There are implications of these findings for both undergraduate and postgraduate medical education.

Key points

- General practice supervision is a powerful method of professional maintenance and development. It is different from Balint groups, peer-group work or personal psychotherapy, although there are some similarities
- Supervision involves a structured and intensive one-to-one relationship between a GP and the supervisor. Some GPs use the supervisor to develop psychotherapy skills in general practice. At present most supervisors are trained psychotherapists
- Supervision assists GPs to resolve personal and professional work-related issues; it helps GPs become more aware of self in the work environment; and it provides insight into the doctor-patient relationship
- By holding and validating the GP in his or her work, the supervisor provides a safe place for professional reflection and challenge
- There are significant personal and cultural

INTRODUCTION

barriers that need to be resolved individually before a GP would decide to use supervision

There has been considerable disquiet in New Zealand in the last decade about the psychological vulnerability of GPs and the apparent low morale in general practice. The RNZCGP has partially addressed these issues with the publication of the Self-care Pack in 19981 followed by a College Forum on "low morale" at the College conference in Wellington in 1999. Peer groups are now well established throughout New Zealand, 2 but combining peer group work with normal CME activities has not been sufficient, so far at least, to raise morale. The April 2000 issue of *New Zealand Family Physician* included an editorial3 and other articles on self-care, so this report of a new method of professional maintenance is timely.

The personal and psychological difficulties for Western GPs are well documented, 4 ,5 with recent evidence that GPs in New Zealand are no exception.6 These studies provide mounting evidence that choosing medicine as a career carries significant occupational hazards. Medicine is but one of many helping professions where there is pressure on the role of the helper in helping relationships. This can create tensions for the helping professional, who is required to temporarily suspend some of his/her own needs in service of the patient or client. Helping can be difficult; while some workers seem to survive and even flourish, others appear to suffer considerable stress,7 sometimes leading to burnout.8 ,9

There is evidence that it is also possible to identify the pre-medical school vulnerability to these stresses.10-12 However, despite a widely available text in New Zealand on self-care10 and a free consultancy service for the health-impaired professional (The Doctors' Health Advisory Service, Wellington), there is no objective evidenceso far that the psychological health of doctors is improving.

This research looked at a method of professional support called supervision that is considered routine in other helping professions.11 Supervision in these disciplines seems to be a well-theorised system of professional maintenance, where health professionals spend dedicated and focused time with a colleague talking about their work.12 In counselling, marriage guidance and social work, for example, supervision is integral to the ethical base of the profession.13 Supervision is quite unusual in medicine, with only occasional GPs and some medical psychotherapists using the method.

It should be clearly differentiated from compulsory supervision of a doctor who has been unwell or has been the subject of disciplinary procedures, where "supervision" has administrative and regulatory connotations. In contrast, the GPs in this research used supervision on a voluntary basis for professional support and clinical development. While educative mentoring could be a more precise term, the word supervision will be used here, being the term used by these respondents.

An in-depth interview methodology was chosen to explore the experiences of a small group of GPs who were already using supervision. This article considers how supervision contributed to their systems of professional support and maintenance.

Research on supervision in medicine

This is the first in-depth study on GP supervision in New Zealand. Freeman14 had initiated a mentoring scheme for GPs in the UK in the 1980s, in response to "increased accountability with decreased professional autonomy" after the health reforms15 of the Thatcher government. The project enrolled 25 mentors for 68 doctors over a three-year period. Funding was provided so there were no financial

barriers, and the role and function of the mentor was defined and developed de novo for the general practice arena. This included education, personal support and professional development of the mentee.

The main outcome of this action research was "achieving change through the medium of a reflective, supportive mentor relationship, resulting in changed perspectives and re-ordering of priorities".

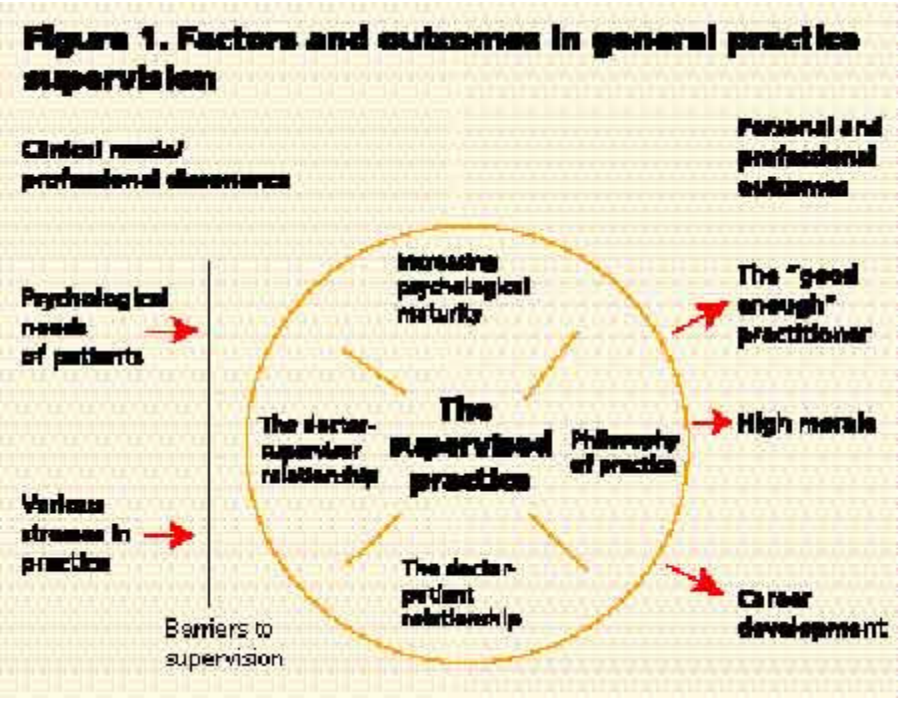
Continual health restructuring in the last decade in New Zealand has similarly increased accountability and reduced autonomy, so it is likely GPs here would be experiencing similar stress to their UK colleagues.

In response to this, Parkinson initiated a "mentoring network" for GPs in the upper North Island, where senior psychotherapists acted as supervisors for rural and urban GPs. The doctors found supervision to be helpful in dealing with changes to the delivery of general practice.16

From the experience of other helping professions and from what little research there is, supervision appears to have the potential of supporting GPs in their work. This research was designed to explore its effect on current practice.

METHOD

Ethical approval was received from both the Otago and Canterbury RHA Ethics Committees. Between June 1998 and May 1999, seven in-depth interviews with GPs from Canterbury, Otago and Wellington were conducted17 to explore the participants' existing experiences of supervision. These GPs were "key informants", as they have led the development of supervision in general practice in the last 20 years. All interviews were audiotaped, transcribed and returned to the participants for further comments.



Four of the participants reviewed the thematic findings at a teleconference discussion, and contributed further data on the doctor-patient relationship. The analysis strategy18 was vigorous, based on grounded theory.19 Analysis of all the data allowed relationships between the common themes to emerge. Detailed review of research philosophy, steps in data analysis and validity have been reported elsewhere.20

RESULTS

There were four major emerging themes:

1. dissonance and tension
2. self-awareness and professional development
3. the supervised practice
4. defining GP supervision.

This article does not have sufficient space to report fully on these themes. Instead, a brief overview of the main findings is outlined in the summary box and Figure 1. The following discussion is limited to the role of supervision in self-care and professional maintenance.

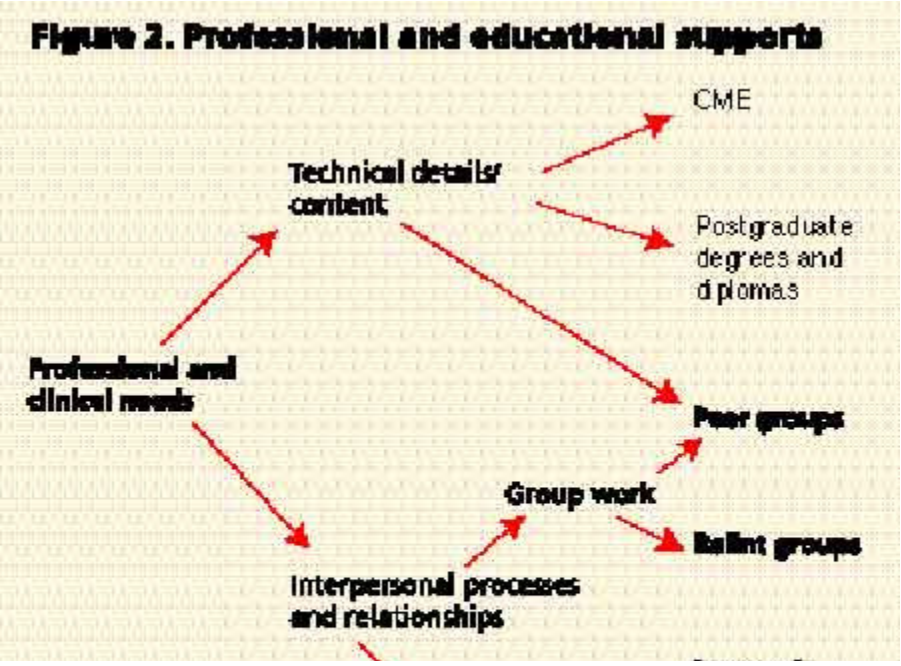
Validation

All the respondents noted how validation or affirmation of their work by the supervisor was important to them. One particular quote illustrates these points (pseudonyms are used):

Paul: Well, what it does is it affirms me, in terms of what I'm doing. It gives value to what I'm doing...there's something very significant in these human encounters...It's not just trivial, it's not just another sore throat. It's something that's got all sorts of other dimensions. And...reaffirming that is very important for me.

As helpers then, being validated is important. General practice can be difficult, there may not be much direct feedback from patients, and the political context is continually changing. Yet these GPs gave the impression of being positive, resourceful, and clear about their sense of purpose with patients. They wanted not just to be told they were doing okay; they also wanted to be critically examined and evaluated. These attitudes seemed to be in contrast to the identified stresses of practice listed above. In short, supervision contributed to a "high morale," and this was a consistent finding for all the respondents.

However, these attitudinal adjustments only occurred after considerable commitment to the process of being supervised. Paul, for example, had used supervision as professional support for several years, so when he was the subject of a complaint from



a patient, his personal response was contained within an existing supervisory relationship. He showed considerable resilience to the stress of the complaints procedure, as this quote illustrates:

Paul: yep, I've been involved with Mrs Stent [The then Health and Disabilities Commissioner]*...Well that was very helpful then, the supervision for that... getting some insights, and talking it through. Took two years to resolve it, and then it all just fizzled out.*

By contrast, some of the GPs in Cunningham's recent study21 were imbued with shame as part of their response to the complaint, with respondents making substantial changes (such as negative defensive medicine) to their style of practice.

This research has identified how supervision was helpful for these respondents, and that the process of supervision peculiar to other professions can be usefully translated to general practice. Other writers have noted how medical training in the 20thcentury has emphasised the biological basis of disease to the relative neglect of psychological factors.22 Supervision, at least in this study, appears to reverse this emphasis, focusing more on interpersonal and relationship issues.

Supervision as part of professional maintenance

Figure 2 is an overview of various forms of professional support identified by these GPs in this study. Their supports were usually related to either *content* (technical advice about diagnosis and treatment) or to *process* (interpersonal issues with patients, staff or colleagues), and the supports could be in either one-to-one settings or in groups.

In their experience, peer groups provided helpful support for both content and process, while GP supervision and personal psychotherapy were both forms of one-to-one development. On review, supervision offers a new form of professional support for GPs based on a one-to-one relationship, covering both professional support and/or ongoing education about interpersonal relationships.

The 'good enough' helper

Why is supervision so effective? Winnicot's concept of the "good enough" mother23 is a helpful analogy about the construct of supervision. The good enough mother is "held" and supported by the father (or another adult) when her child is difficult and needy. By being held herself, she does not sink under feelings of inadequacy or guilt, but can "hold" the child even in the most difficult of circumstances.

In supervision, the good enough helping professional can survive the multiple pressures from patients and/or work situations by being held within the supervisory relationship. Feelings of inadequacy, insecurity or guilt can be worked through in that forum, which can also provide intensive training on specific learning needs such as counselling or psychotherapy skills.14 It is no surprise then, that many helping professions now use supervision as their preferred system of providing support and ongoing education.

DISCUSSION

If supervision is so helpful, why are more GPs not using this method? The superficial answers could be: there are other more effective methods of professional maintenance; GPs are coping satisfactorily as is. The available evidence does not support either of those theories. The answers to this paradox lie in the ongoing barriers to supervision in medical culture. Unfortunately, the barriers listed in the summary box (paragraph 2) appear to be endemic in medical education and practice.

While the findings of this study suggest these respondents were positive about supervision, these barriers seem to be its major limitation.

These included being unaware of the concept of supervision, vulnerability to perceived criticism, emphasis on "knowing" in a knowledge-based culture,24 ,25 the tradition of observer detachment,26 constraints of time and cost, and previous experiences of shame-based undergraduate education. All these factors contribute to a perfectionist culture in which talking frankly about one's work is seen as a sign of weakness, rather than of proactive learning.27 ,28 ,29 One further quote illustrates this:

Robyn: Yeah. It is the culture of general practice that's the barrier.

Well, I think it's the culture that came from the hospital, medical students go and get indoctrinated into the hospital culture, before they get to be GPs, and the hospital culture that I perceive is power games, or one-upmanship.

If you look at the littlest medical student, you go on rounds, and the registrar's giving the house surgeon a hard time, by showing that he's smarter than the house surgeon, and the consultant's giving the registrar a hard time, by showing that he's smarter than the registrar, and the house surgeon's either giving the medical student a hard time, or the nurses a hard time, 'cause they're the lowest on the medical pecking order.

So, you grow up in this culture, where you can't afford to expose any of your weaknesses, 'cause there's somebody in your medical culture who'll use those against you. I think that's the culture we grow up in, in medicine, so, it's really hard to be open with your colleagues, when you've come out of the pecking ground.

There are some signs, however, that medical education is changing. Students at Otago University are now part of "mentoring" groups during their clinical years, where they meet regularly with a mentor. In the long term, it is hoped that positive experiences of mentoring (or supervisory) relationships will reduce some of these barriers to self-care in medical culture. Similarly, reflective learning is becoming established with more aspects of the learning cycle30 being included.

CONCLUSIONS

Robyn: The process of supervision is about making an intimate relationship with your supervisor...that's a big step for medicine.

In doing it safely within the supervision environment, it allows you to learn that you can actually do that within your office environment...So, it's a model of how you can actually run your professional life.

This research found that validation and support of GPs by a trusted and respected supervisor allowed professional and personal growth, even in a period of considerable uncertainty and change in the culture of general practice. Supervision enabled these particular doctors to survive and flourish when other GPs had been complaining of low morale and considerable work-related stress.

While the findings of this research point strongly to supervision being helpful, the barriers to supervision or other forms of mentoring are endemic in medical culture, and these form the main limitation of supervision as a more widespread method of professional maintenance. One implication is that supervision will gain acceptance only by the example of those enjoying it as a method of support and development.

Future study

The main limitation of this study was the lack of a comparative group who did not use supervision. Further research could be directed to comparisons between supervised and unsupervised GPs, measuring general wellbeing and psychological traits in response to stress. Outcomes of practice such as prescribing or referral rates between the two groups would have financial implications. The hidden issue of shame embedded in the learning culture of medicine is in urgent need of further research.

Acknowledgements: I would like to thank the participants who were so generous with their time and ideas. Thanks also to my research supervisor, Dr Anne Bray from the Donald Beasely Centre, Dunedin, for her valuable advice throughout this research. This study received no external funding support. The conclusions are those of the author; no endorsement by the RNZCGP is intended or implied. Thanks to Mr Tony Egan and Dr Wayne Cunningham for valuable editing advice.

Correspondence: Dr Hamish J Wilson, Department of General Practice, PO Box 913, Dunedin. Phone (03) 479 7430, Fax; (03) 470 7431. Email: hwilson@gp.otago.ac.nz

• *Hamish Wilson works part time in general practice, and his interests include consultation analysis and the relationship between interviewing styles and physical outcomes. He is currently researching how doctors themselves respond to illness and its subsequent effect on practice.*

References

1. Barker N. *Self-care of general practitioners*. RNZCGP, Wellington, 1998.

2. Watson A. *The peer-group movement. What goes into making a successful peer group?* RNZCGP, Wellington, 1997.

3. Turnbull T. A personal note on doctor health. *NZ Family Physician* 2000;27 (2):5.

4. Cooper CL, Rout U, Faragher B. Mental health, job stress among general practitioners. *BMJ* 1989:298:366-370.

5. Winefield H, Murrell T, Clifford J. Sources of occupational stress for Australian GPs, and their implications for postgraduate training. *Family Practice* 1994;11:413-417.

6. Dowell A.C, Hamilton S, McLeod D. Job satisfaction, psychological morbidity and job stress among New Zealand General Practitioners. *NZMJ* (in press).

7. Payne R, Firth-Cozens J. *Stress in health professionals.* John Wiley; London:1987.

8. Kirwin M, Armstrong, D. Investigation of burnout in a sample of British general practitioners. *British Journal of General Practice* 1995;45:259-260.

9. van Dierendock D, Schaufeli WB, Sixma HJ. Burnout among general practitioners: A perspective from equity theory. *Journal of Social and Clinical Psychology* 1994;13:86-100.

10. Vaillant GE, Sobowale NC, McArthur C. Some psychological vulnerabilities of physicians. *N Engl J Med* 1972;276:372-5.

11. Brevin CR, Firth-Cozens J. Dependency and self-criticism as predictors of depression in young doctors. *J Occupational Health Psychology* 1997; 2(30):242-6.

12. Revel A. The psychological needs of doctors and their mental health. *MGP Proceedings.* University of Otago, Dunedin, 1996.

13. O'Hagan J, Richards J. *In sickness and health. A handbook for medical practitioners, other health professionals, their partners and their families.* Doctors' Health Advisory Service: Wellington, 1997.

14. Hawkins T, Shohet R. *Supervision in the Helping Professions.* Milton-Keynes, Open University Press, United Kingdom, 1989.

15. Leddick GR, Bernard J. The history of supervision: A critical review. *Counsellor education and supervision* 1980;19(3):186-196.

16. Williams A. *Visual and active supervision.* Nortons: New York, 1995.

17. Freeman R. *Mentoring in General Practice.* Butterworth Heineman: London, 1998.

18. Sutherland VJ, Cooper CL. Job stress, satisfaction, and mental health among general practitioners before and after the introduction of the new contract. *BMJ* 1992;304:1545-1548.

19. Parkinson P. Mentoring for general practitioners. *GP Weekly*; 1998; February 25.

20. Patton MQ. *Qualitative evaluation and research methods,* 2nd ed. Newbury Park, CA: Sage Publications, 1990.

21. Maykut P, Moorehouse R. *Beginning Qualitative Research: A Philosophic and Practical Guide.* Falmer Press, London: 1994.

22. Lincoln YS, Guba EG. *Naturalistic enquiry.* Beverly Hills, CA: Sage Publications, 1985.

23. Wilson HJ. *Supervision and the culture of general practice*. MGP thesis, University of Otago 2000.

24. Cunningham W. *The effect on New Zealand general practitioners of receiving a complaint from the (former) Medical Practitioners Disciplinary Committee.* MGP thesis, University of Otago, 1999.

25. Broom B. *Somatic illness and the patient's* other *story.* Free Association Books, London: 1997.

26. Winnicot DH. *Maturational processes and the facilitating environment.* Hogarth Press, London: 1965.

27. De Forge B, Sobal J. Intolerance of ambiguity in students entering medical school. *Soc Sci Med* 1989;28:869-874.

28. Fox RC. The evolution of uncertainty. Millbank Memorial Fund Quarterly/ Health and Society 1980;58(1):1-49.

29. Wilson HJ. The myth of objectivity. *Family Practice* 2000;17:203-209.

30. Lidmila Alan. Shame, knowledge and modes of enquiry in supervision. In: Shipton G, (ed). *Supervision of psychotherapy and counselling: Making a place to think.* Buckingham, England: The Open University; 1997: 35-46.

31. Talbot NL. Unearthing shame in the supervisory experience. *American Journal of Psychotherapy* 1995;49(3):338-349.

32. Kozlowska K, Nunn K, Cousens P. Adverse experiences in psychiatric training. *ANZJ of Psychiatry* 1997;31(5):641-652.

33. Kolb D. *Experiential learning: experience as a source of learning and development.* Prentice Hall: New Jersey, 1984.

Summary of findings

Dissonance and tension

Prior to starting supervision, the GPs in this study had identified the dissonance between their current skills and their needs in practice. Firstly, they needed back-up for their counselling and psychotherapy interests, especially when taking patients for formal hour-long sessions. Secondly, they used the supervisor as a sounding board to review the tensions of professional life, including peer relationships and practice management. The supervisors seemed to validate their experiences and philosophy of practice.

Before initiating supervision, respondents identified significant cultural beliefs that acted as barriers to supervision. These related to previous experiences of shame-based teaching and constraints of time and cost. Once these barriers were overcome, they experienced considerable relief from talking in a respectful environment about their work, and they gradually developed confidence in the supervision process.

Professional development and self-awareness

These GPs used supervision to not only review their patients, but also to reflect on their philosophy of practice. Supervision facilitated recognition of learning needs and encouraged self-directed learning. The GPs wanted to be challenged and criticised in a safe environment. Supervision became a place to discuss career directions and overall professional development. Supervision helped GPs become more self-aware of the minute-to-minute issues in a consultation. Participants were not supervising other GPs, but did consider that they may eventually do so.

The supervised practice

Respondents wanted to work with both physical and psychological complaints, and by having supervision for the counselling side of their practice, they gained more confidence with other patients as they could recognise and deal with emotional factors in those consultations. These GPs sometimes tried to shift patients from a physical focus to a more psychological one. They stressed the importance of interpersonal relationships with their patients as part of "healing" or recovery, using supervision to identify and work through any difficulties.

The supervisor needed to have psychotherapeutic skills, but could be a psychotherapist or a doctor. The doctor-supervisor relationship was an important aspect of a supervised practice. These GPs felt respected by their supervisors, and this modelled a way of relating to their own patients. Supervision helped to clarify boundary issues in their role as GPs.

Defining GP supervision

Respondents met with their supervisor usually fortnightly to discuss all aspects of their work. The cost was between $50 and $75 per hour. One-to-one supervision was seen by these respondents to be different from group supervision, from work in peer groups, from Balint groups, and from personal psychotherapy. Group supervision was cheaper, allowing GPs to see how others coped with similar patients, but group work was perceived to increase participants' vulnerability.

Peer groups provided GPs with collegial and technical support, whereas supervision provided more specific interpersonal support for working with "difficult" patients, for counselling back-up, for discussing their philosophy of practice and for certain specific situations. Compared to personal psychotherapy where the focus was on self-development, the focus in supervision was on work and professional life. Personal psychotherapy could also help GPs in their work by increasing their awareness of self in the doctor-patient relationship.