



University of HUDDERSFIELD

University of Huddersfield Repository

King, Nigel, Roche, Tracy and Frost, Chrystal

Diverse Identities, Common Purpose: Multi-disciplinary Clinical Supervision in Primary Care

Original Citation

King, Nigel, Roche, Tracy and Frost, Chrystal (2000) Diverse Identities, Common Purpose: Multi-disciplinary Clinical Supervision in Primary Care. In: British Psychological Society Annual Occupational Psychology Conference, January 2000, Brighton, UK. (Unpublished)

This version is available at <http://eprints.hud.ac.uk/id/eprint/18874/>

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: E.mailbox@hud.ac.uk.

<http://eprints.hud.ac.uk/>

Diverse Identities, Common Purpose: Multi-disciplinary Clinical Supervision in Primary Care

Dr Nigel King, Ms Tracy Roche & Ms Chrystal Frost

Primary Care Research Group
School of Human and Health Sciences
University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Paper presented at the British Psychological Society Annual Occupational Psychology Conference, Brighton, January 2000.

Introduction

The rise of multi-disciplinary work in contemporary organisations has been widely discussed by occupational psychologists, often in the context of the increasingly fashionable topic of "managing diversity". Jackson (1996) argues that the increasing reliance on multi-disciplinary teams can be understood in terms of the response of organizations to the demands of changing domestic and international markets. Organizations of all sizes have seen innovation and responsiveness to customers as the twin solutions to the new challenges they face, and these solutions are commonly held to be facilitated by structures incorporating multi-disciplinarity.

Persuasive though Jackson's explanation is in relation to commercially-oriented organizations, it cannot fully account for the parallel growth of multi-disciplinarity in public sector organizations, especially the health and social care sectors. In the UK, the growing emphasis by policy makers on primary health care services has been of central importance. Because primary care is concerned with addressing the health problems of people within their homes and communities, rather than in institutional settings (hospitals), it has tended to take a more holistic view of health than the mechanistic biomedical model. This in turn leads to a blurring of the

traditional distinctions between medical care and nursing care, and between health care and social care. As a result it is generally acknowledged that effective primary care needs to be delivered by a genuinely multi-disciplinary team. While it is hard to deny the value of multi-disciplinarity in principle, to achieve it in practice is fraught with difficulty. The different professional and occupational groups within primary care contrast in power, status, culture, professional organization, and values. If we focus just on the medical and nursing professions, there are enormous potential barriers to true collaborative work:

1. The historical relationship between medicine and nursing

"Paternalistic" is perhaps an over-used term in the social scientific study of organizations, but it describes precisely the historical relationship between medicine and nursing. When nursing emerged as a distinct discipline in the late 19th century, its role was entirely subservient to that of doctors, mirroring the subservience of women to men in Victorian society. As Bond and Bond (1986) state; "...the nature of interprofessional relations...reduced the nurse to a non-scientific aide whose authority derived from her relation to medicine. Thus nursing became an occupation *primarily defined by its responsibility for executing medical orders and directives* [original authors' italics]." (p. 301). While there have undoubtedly been major changes in this relationship over the past century (particularly in the last two decades), it still remains one where the balance of authority rests with doctors.

2. The cultural values of medicine and nursing

Related to their different histories, the medical and nursing professions exhibit different cultural values. Through formal education and informal socialization processes, doctors are taught to value their role as autonomous decision-makers, proactive and decisive (Sinclair, 1997). Nurses, as we have noted, have historically valued obedience to authority, not only to that of the doctor but also to their own superiors in what is a highly hierarchical profession, modeled closely on a military-style structure of ranks. The time is not very long-passed when student nurses were required to obtain Matron's permission to get married.

Another difference in values can be put simply in terms of "curing vs. caring". Medicine has defined its core purpose as curing illness (or other

dysfunction); circumstances where cure is not a possibility can create difficulties for doctors - for example in dealing with terminal illness (eg, Buckman, 1984). Nursing places greater value on caring - alleviating suffering, comforting distress and understanding the patient's health problems in the context of their wider life.

3. Differing contractual arrangements of GPs and Community Nurses

In the UK, GPs are not employees of the NHS but are independent contractors to it. This strengthens still further their power and autonomy compared to that of nurses working in primary care. Practice nurses are generally employed directly by practices, and are therefore in an employee-employer relationship with GPs. In contrast, District Nurses and Health Visitors are in most cases employed by NHS Trusts and attached to practices (sometimes to more than one). They thus have line management outside of the primary care team.

Background to the present study: Multi-disciplinary clinical supervision

This paper examines the impact of professional diversity on group dynamics and outcomes in the specific context of a multi-disciplinary clinical supervision group in primary care. We will outline the aims and methodology of the study in subsequent sections; here we will provide some background detail on the concept and practice of clinical supervision.

The concept of Clinical Supervision

Clinical supervision has been defined as “an exchange between practising professionals to enable the development of professional skills” (Butterworth 1993). It is a process based on a clinically focused, professional relationship between a practitioner engaged in clinical practice and a supervisor who is able to apply clinical knowledge and experience to assist their colleague to develop practice, knowledge and values (Darley, 1994). It first developed within the disciplines of counseling and psychotherapy (Martin et al 1989) and has been widely adopted and adapted in nursing and other health professions. It is not evident in medical practice, although mentorship schemes, which are similar (though not identical) to clinical supervision, are increasingly used (Puetz 1985).

Group supervision

Most research has examined clinical supervision on a one-to-one basis, as this remains the dominant form used. However, group supervision is also used quite frequently, though it has received much less attention from academics. There are a number of potential advantages to group supervision which may attract health professionals and managers to it: (1) it may provide opportunities for participants to deepen their understanding of the professional roles of colleagues and the challenges they face; (2) it may facilitate team-building; (3) it may be more cost-effective in terms of staff time than one-to-one supervision.

These first two features in particular may make group supervision a valuable resource in multi-disciplinary settings, such as primary care teams. However, alongside its strengths, there are some significant pitfalls to be aware of. Firstly, it may be problematic if there are power and status differences between participants (formal or informal). Clinical supervision is not an exercise in managerial responsibility and should not be hierarchical in nature. Secondly, marked differences in professional roles and identities may create communication difficulties. The group may become bogged down in members' attempts to explain the nature of their work to each other.

Aims

The study set out to evaluate a pilot multi-disciplinary clinical supervision (MDCS) scheme in Northern England, in terms personal and professional benefit to participants, and potential for further extension and development of the scheme in other practices. The analysis presented in this paper addresses specifically issues of multi-disciplinary teamwork as outlined in the introduction. We seek to answer the following question:

How does the professional diversity in a multi-disciplinary clinical supervision group impact upon the dynamics of the group and its outcomes for participants?

Method

Participants

The participants were all members of one General Practice team, who had worked together for many years. They consisted of: one District Nurse, one

Health Visitor, one Practice Nurse, and one General Practitioner. (The GP was male, the nurses all female). The first two were employees of the local Community and Mental Health Trust, attached to the Practice. The Practice Nurse was an employee of the practice, at which the GP was a senior partner. The Practice was situated in an urban area, dominated by large council estates with a high level of deprivation. Of the three nurses, only the Practice Nurse had not experienced clinical supervision before, while the GP had experience of mentorship schemes. The Practice was noted for its involvement in a wide range of innovative schemes and research projects in primary care, and the participants had, in various combinations, worked together in the recent past on a number of these initiatives. Prior to the pilot, which ran for four 90-minute sessions, all participants attended two training sessions, each lasting two-and-a-half hours. These covered issues such as: definitions of clinical supervision; contracting and ground rules; the roles in group supervision; and reflective practice. The reflective cycle as described by Gibbs (1988) was offered as a framework for sessions, and this was adopted without alteration by the group.

Procedure

This project utilised a qualitative case-study methodology, to enable the research team to gain a detailed understanding of participants' experiences of and feelings about the scheme. Prior to the start of the pilot, we carried out brief interviews with the participants, to identify their previous experience of clinical supervision, and to examine their hopes and expectations regarding the scheme. The main study was in two stages:

Stage 1: Observation and recording of sessions

All four MDCS sessions were tape-recorded and these recordings transcribed in full. In addition, at least two members of the research team attended every session and took detailed notes, particularly of aspects of the sessions which would not be evident from audio-tape transcripts (such as the non-verbal behaviour of participants).

Stage 2: Post-pilot interviews

The participants were interviewed individually, using a semi-structured approach, to examine their opinions of the scheme. While the interviews were kept flexible enough to allow participants to raise the issues which

they personally felt to be important, certain key areas for evaluation were covered in all cases. These were:

- their feelings about the training sessions
- the utility of the clinical supervision model applied in this pilot scheme
- their experiences, positive and/or negative, of taking the various roles defined in the scheme (i.e. facilitator, supervisee, group member/supervisor)
- how and why they chose their issue to bring as supervisee
- the extent to which there had been progress on their issue after their supervision session
- their feelings about future participation in MDCS

Analysis

The post-pilot interviews were analysed using the “template analysis” approach (King, 1998), which involves defining themes relevant to the research aims within and across interviews, from which a “template” is constructed to serve as the basis for interpretation. The observational notes were then examined to identify sections of the MDCS sessions where issues relating to themes from the analytical template arose, to help us put the interview analysis into the context of what actually happened during supervision. For example, if a participant described a particular episodes in one session as being of special importance in the outcomes of the session for her/him, we examined the records of that session to try to deepen our understanding of why the episode had the impact it did.

Findings and Discussion

We will discuss the findings in two broad areas which are especially relevant to our interest in the impact of professional diversity: *power and status issues*, and *inter-professional communication and understanding*. (Given the space restriction for this paper, we can only provide an overview of the main points here).

Power and status

Issues of power and status can pose a major threat to the success of any multi-disciplinary team activity, especially one as reliant on mutual trust as clinical supervision. The pilot group encompassed not only the divide between medicine and nursing, but also, in relation to the GP and Practice

Nurse, that between employer and employee. Status differences also exist between nursing groups, relating to autonomy, the nature of responsibilities, and training; Health Visitors would probably tend to be seen by other primary care staff as having the highest status, and Practice Nurses almost certainly the lowest.

Through their training and their previous experience working together, the pilot group were alert to the dangers in this area; power issues were discussed during training and a real effort was made to minimise their effect. In the main this was achieved; members expressed trust in each other and demonstrated it in their openness during supervision. This is not to say that such issues were entirely absent from the sessions. In her session as supervisee, the Practice Nurse was very evidently anxious about how the GP would respond to the issue she brought. When the GP responded positively, legitimising the Practice Nurse's concerns, the latter's relief was unmistakable. In the interview, she described her feelings at this point in the supervision session as "elated".

There were occasions in the sessions when the nurses intervened as a group, presenting a "nursing" perspective to the GP on a particular topic, or expressing common surprise at aspects of the GP's work which they had been unaware of. It was notable, too, that the nurses without fail used each others' first names, while they spoke or referred to the GP by title and surname. Power issues of a different kind were apparent in the practicalities of running the MDCS sessions. The GP was only able to arrange full locum cover for himself for every session. Despite his genuine efforts to ensure other members were not disadvantaged by their participation, all the nurses were forced on at least one occasion to use their "own" time to attend - for example, using up part of their lunch hour, or coming in when not on duty.

Inter-professional communication and mutual understanding

This is widely recognised as an area of concern in the literature on multi-disciplinary teams, especially as research suggests that communication networks in organizations tend to be professionally/occupationally homogenous (Jackson, 1996). At the same time, the opportunity for learning and personal growth through exposure to others' perspectives is one of the most valuable potential gains from diversity in work groups.

In the present study, communication difficulties relating to professional identities were rare, and minor when they did occur. In part this probably reflects the largely shared common technical language and associated jargon across nursing and medicine (not always the case in occupationally diverse teams). It also reflects the fact that this was a self-selected group who had worked closely with each other in the past, on special projects as well as in their day-to-day practice. This relatively high level of mutual understanding at the start of the pilot might be expected to have a down-side; namely, that there would be little the group could learn about each other through the short series of four pilot sessions. However, all the participants reported having learnt something significant about at least one other member of the group. Some comments were about personal characteristics, others related specifically to aspects of people's jobs. In the latter category, most of the discussion was about what the GP had learnt about the nurses' work, and vice versa. This is not surprising given that the three nurses in the group share a professional background and tend to have more contact with each other than with the GP.

Despite the good inter-professional communication within this group, it is worth noting that none of the participants felt that MDCS should replace one-to-one clinical supervision (or mentoring) with a professional colleague). This was largely because of the perceived limits to mutual understanding across professions (even across branches of the same profession in the case of the nurses). MDCS was most appropriate for issues where participants' shared identity as part of the same primary care team facilitated mutual understanding; it was notable that none of the issues brought to the group supervision sessions was a narrowly clinical one.

Conclusion

Overall, this pilot should be regarded as successful in achieving constructive collaboration across professional boundaries. The nature of the process in the group undoubtedly contributed greatly to the valuable outcomes of the pilot scheme as a whole. Three of the four issues brought to the sessions had seen substantial progress by the end of the post-pilot interviews, and one year later some important changes in the Practice as a whole had been implemented as a direct result of the MDCS sessions. This success can be

attributed to certain features of the pilot group, alluded to earlier: it was self-selected, participants knew each other well and had worked together on projects outside their normal duties before (though not in precisely this combination), they entered the pilot with enthusiasm, and they belonged to a primary care team that strongly valued innovation.

Despite this positive conclusion, there were still actual or potential problems associated with professional diversity in the group. As we have seen, the difference in the GP's contractual relationships with the Practice Nurse on the one hand, and the Trust-employed nurses on the other, impacted on the Practice Nurse's experience. While the outcome on this occasion was good, in future sessions the Practice Nurse would always be more dependent upon the GP's support for a favourable outcome than would the nurses not employed by the Practice. The GP's status as an independent contractor to the NHS made it far easier to arrange cover for himself to attend the pilot sessions than for other group members (especially the Trust staff), who therefore made greater sacrifices in terms of their own time to attend. In the longer term, this inequity could undermine their commitment to the group. Finally, the reluctance of participants to accept MDCS as a substitute for one-to-one supervision within their professional group indicates the limits to mutual understanding, even in an effective multi-disciplinary team.

References

- Bond, J & Bond, S (1986) *Sociology and Health Care*, Edinburgh: Churchill Livingstone
- Buckman, R (1984) Breaking bad news: why is it still so difficult?, *British Medical Journal*, **288** (1), 1597-9
- Darley M. (1994) The UKCC Perspective. In *Clinical Supervision conference proceedings*, NHSME, Birmingham.
- Gibbs G (1988) *Learning by Doing: A guide to teaching and learning methods*. Further Education Unit: Oxford Polytechnic, Oxford.
- Jackson, S (1996) The Consequences of Diversity in Multidisciplinary Work Teams. In M. West (ed.) *Handbook of Work Group Psychology*, Chichester: Wiley
- King, N. (1998) Template Analysis. In *Qualitative Methods and Analysis in Organizational Research*, C.Cassell & G.Symon eds.), London: Sage.
- Puetz B E (1985) Learn the ropes from a mentor *Nursing Success Today* **2**,(6) pp 11 -13
- Sinclair, S (1997) *Making Doctors*, Oxford: Berg