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## Moving on from Balint: embracing clinical supervision

Apart from general practice, most of the helping professions now have an established culture of clinical supervision.<sup>1</sup> Some professions, like counselling, consider supervision to be essential for sustaining reflective practice, and they have made it a requirement for continuing accreditation. Other professions, such as nursing, seem to be moving in that direction.<sup>2</sup> Although it is sometimes seen as part of management, clinical supervision is properly regarded as something non-hierarchical, non-judgmental, and focused on the practitioner rather than the organisation.<sup>3</sup> It addresses the need for support and development, and it is also anchored in an awareness of performance standards, patient safety, and public accountability.<sup>4</sup>

Supervision can be used to address the emotional impact of patient encounters, and to examine the technical aspects of case management, and issues within the team and workplace.<sup>5</sup> There are many approaches to supervision, including one-to-one sessions or group meetings. These activities all share the same purposes. Morton-Cooper and Palmer<sup>6</sup> define these as:

- clarifying human values;
- acquiring emotional literacy;
- recovering meaning in social relationships;
- providing skill rehearsal and role models;

- evaluating and disseminating best practice in health care; and
- protecting against disorientation, disillusionment, and burnout.

Supervision, like any activity, can be done inexpertly or lead to collusion.<sup>7,8</sup> However, there is evidence that good supervision contributes to general wellbeing, knowledge, confidence, morale, understanding, self-awareness, job satisfaction, and endurance.<sup>9–12</sup>

Many people are surprised to find that most GPs do not receive clinical supervision. GPs do discuss cases, although most commonly in the corridor, over coffee, or in phone calls to local specialists. Other activities such as primary care team meetings, and even appraisals, can provide occasions for in-depth discussion of specific cases. A small minority of GPs make arrangements for mentoring, coaching, or even personal counselling or therapy. These approaches may provide effective forms of supervision. However, it is still possible to go through a whole career in general practice without any sustained, regular, and meaningful exchanges with colleagues about the day-to-day challenges of seeing patients. This seems an anomaly, given the technical and psychological complexity of our work.

There are many reasons for the divergence between GPs and other professions in terms of supervision. The culture of self-sufficiency in medicine may deter doctors from acknowledging a routine need for help. GPs in particular have traditionally worked as autonomous practitioners rather than as team members. Heavy workload can limit opportunities for supervision which may appear as yet another demand. Most doctors probably still understand supervision to mean surveillance or management, rather than peer support, and this may contribute to their avoidance of it.

As we move towards multidisciplinary work, more public accountability, and systems of re-accreditation, it seems reasonable to expect GPs to develop their opportunities for case-based discussions. Sooner or later, we will need to give a formal account of how often we check our day-to-day case management, how we do it, and with whom. Whether we decide to call this activity 'clinical supervision' probably matters less than whether we take ownership of it. This process should be led by professional needs rather than managerial ones.

One possible form of supervision for GPs can be found in the context of Balint groups. Pioneered at the Tavistock Clinic 50 years ago, these groups have been the

most enduring model for GP supervision. Many GPs have described how Balint groups have helped them to survive general practice, or have transformed their working lives. In spite of this, Balint groups have only ever attracted a small number of doctors, and they have been on the wane for many years.<sup>13</sup> In Britain, including the Tavistock Clinic itself, Balint groups are virtually defunct (apart from the Balint-type discussion slots in some training schemes). Balint group leaders regard this decline as part of a dumbing down of whole-person general practice, in favour of a target-driven, technocratic view of the job. However, an approach that only addresses psychological aspects of consultations, and has never appealed to most GPs, may have inhibited GPs from exploring alternatives. It may have discouraged our profession from making clinical supervision a more widespread activity.

Other models of supervision for GPs exist. For over a decade, the Tavistock Clinic has promoted a 'post-Balint' approach to case discussion using ideas and skills drawn from narrative-based medicine, systemic therapy, and from contemporary forms of postgraduate GP training.<sup>14</sup> This involves explicit teaching of the micro-skills for effective one-to-one or group clinical supervision. We try to impart skills that can be applied not just in formal supervision, but also in informal workplace conversations. We base much of our approach on established methods of training in consultation skills, which bear much resemblance to supervision skills. We use a great deal of closely supervised small group work and video review. In a considered reaction against Balint-style techniques, we actively encourage group members to ask pertinent questions, to include technical issues in the discussion where necessary, and not to limit the focus to the doctor's feelings unless this is the request of the colleague bringing the case for discussion. Our overall aim is to teach GPs how to help their peers and juniors find their own resolutions — both emotional and pragmatic — for their work problems.

A related project at the London Department of Postgraduate GP Education (the 'London GP Deanery') has used the

same approach to provide half-day or 1-day supervision training workshops for several hundred GP trainers and appraisers in the London region over the past 3 years.<sup>15</sup> Around 120 people have subsequently elected to participate in more intensive 3-day training to enhance their skills in supervising peers and juniors. Seventeen GPs now attend an ongoing supervision seminar at the Tavistock, which we hope will equip them to become supervision trainers. Other deaneries around Britain have commissioned workshops and courses, and we know of initiatives based on similar ideas elsewhere, including the Nordic countries and Israel. Some of these initiatives draw on best supervision practice both from Balint work and the more structured and pedagogic approach that we now take at the Tavistock.

The time has arrived for experimentation and pluralism in clinical supervision for GPs. We need to motivate GPs to find time for discussing a random or purposeful selection of their cases on a regular basis, using existing skills as well as ones they have newly learned. We should seek to value and enhance all the various forms of peer support that are already in place. We should draw on the huge fund of educational expertise that exists in other areas of postgraduate education, including consultation skills training, as well as the wisdom and experience of the Balint movement.

Rather than lamenting the demise of Balint groups, there is an urgent need to develop and research other approaches, and their effects on patient care.<sup>16</sup> Whether or not we learn to love the word supervision, we should embrace the activity itself in a multiplicity of forms, and make sure that these serve ourselves and the public well.

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#### Conflict of Interest

John Launer is organising tutor of supervision seminars at the Tavistock Clinic and clinical supervision lead at the London GP Deanery. He has received payment from other deaneries, primary care trusts, and universities in Britain and abroad, for workshops and courses in clinical supervision.

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