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SUPERVISION AND THE CULTURE OF
GENERAL PRACTICE

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A thesis presented in fulfillment of the requirements of the degree of Master of General Practice

University of Otago
Dunedin
New Zealand

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ABSTRACT

Supervision is a well-known and well-theorised activity in some professions where experienced practitioners contract to facilitate, guide or educate the novice. Supervision is uncommon in medicine, which has traditionally employed more didactic teaching processes. In the general practice community in New Zealand, practitioners use a variety of methods of professional maintenance, with educative mentoring or supervision being a recent innovation. In this form of supervision, general practitioners (GPs) discuss their work with an experienced supervisor, with one focus being to learn counselling or psychotherapy skills.

This study examined the experiences of GPs who use supervision, with particular reference to how supervision impacts on their practice of medicine. The context for this inquiry included the background philosophical assumptions of the biomedical paradigm, current problems in clinical practice and the culture of general practice in New Zealand.

The research used a qualitative methodology, with seven GP respondents being interviewed at length about their use of supervision. A focus group with four of the participants followed initial analysis of the individual interviews. Interviews and group discussion were analysed within a social constructivist paradigm.

The respondents' stories of learning about supervision led to the construction of a collective story. This could be outlined under the four broad themes of dissonance and exploration, self-awareness and professional development, the supervised practice, and defining supervision in general practice.

However, before these GPs could make effective use of supervision, they needed to work through a number of personal and cultural barriers. The findings of the research suggest that supervision is a powerful method of learning, being an embodied experience through the supervisor-doctor relationship. Some of these GPs used their supervisor to learn how to do psychotherapy in general practice. The supervisor also acted as sounding board for
all the respondents to discuss other work issues, such as practice management and peer relationships. One outcome of regular supervision was validation about their work, contributing to a heightened sense of self in the work environment. Supervision facilitated a model of reflective learning that is relatively uncommon in medicine. This was achieved through rigorous attention to self-awareness, resulting in facilitated career development.

In a supervised practice, the GP incorporates an increasing acuity for patients' psychological problems. There is an emphasis on the doctor-patient relationship, with awareness of the roles and boundaries around the GP's work.

Supervision was seen to be different to work in peer-groups or in personal psychotherapy, but there were similarities. The role of the supervisor was defined to include sub-roles of teacher, facilitator, analyst and evaluator. In this study there was invariably no form of summative evaluation. The results led to a definition of supervision in general practice.

Studying these successful supervisor-doctor relationships gave unique insights into the barriers that prevent further utilisation of supervision or other forms of mentoring in general practice. These barriers include broad issues of the traditional epistemological assumptions of modern medicine. Having supervision appeared to have a major impact on the style of medical practice that is exhibited by these GPs. There are implications of these findings for both undergraduate and postgraduate medical education.

This research was grounded in a social constructivist paradigm that linked theory, research and clinical practice. From the evidence presented here, these practitioners have incorporated biomedicine into a wider medical model that offers a resolution to the current paradigmatic crisis of modern medicine.
ACKNOWLEDGEMENTS

Many people have provided me with support and encouragement in the three years it has taken to complete this thesis. Firstly, I wish to sincerely thank the participants, who were generous with their time and wonderfully open about their work and their ideas on clinical practice.

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Fourthly, thanks go to Drs Jim Reid and Pat Farry, for their early inspirational efforts in the Masters programme; further thanks go to Dr Reid for his review of the final manuscript. Thanks also to Professor Keith Ballard, whose course on qualitative research in 1999 both informed and validated the work in progress.

Finally, heartfelt thanks go to my family, who have been patient and supportive for the past three years while I have been doing this research.
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CHAPTER 1: Introduction

What is supervision in general practice? When asked this question, I have found it difficult to give a short and adequate answer. Inevitably, there seems to be a difficulty with definitions. Even if a satisfactory one is found, the next questions are: "Why? Why would general practitioners want to have supervision? Don't they know enough already? Were they inadequately trained, or is there not enough ongoing medical education?"

In my view, these naive questions arise from historical roots of modern medicine and from certain assumptions within the current culture of general practice. To ask more pertinent questions of supervision then, one needs to review such history and to articulate what it is like to be a general practitioner at present in New Zealand. In this way, the reasons for general practitioners (GPs) starting to use supervision will become apparent, the ongoing blocks and barriers that prevent its further uptake will emerge, and the impact of supervision on the culture of general practice can be identified.

This thesis is the final requirement for the Masters degree in General Practice, the first three years of which comprised formal study in various papers at Otago University, and with the last three years being orientated around the research reported here. I chose to study supervision for several reasons. Firstly, I had touched on some of the issues already in some of the early assignments in this degree, and this thesis was an opportunity to explore those issues in further depth. Secondly, I wanted to research the field of experience, rather than more traditional outcome-orientated studies. Thirdly, I wanted to study doctors themselves, as in my view doctors are an under-researched component of the health care system. Studying the experience of GPs in their use of supervision fulfilled all these criteria.

The main aim of this research was to explore how GPs started supervision, what particular barriers needed to be worked through, and how using supervision affected their clinical practice and their professional development. Such in-depth discussion would inevitably lead to quite explicit articulation about their philosophy of practice, a subject
CHAPTER 1: Introduction

that is taken for granted in much of medicine, but one in which there are important conceptual issues.

Supervision as defined in this thesis, is a voluntary system of professional maintenance, in which GPs spend dedicated and focused time with another health professional, talking about their work. It is a system derived from other disciplines such as counselling, marriage guidance or social work, in which supervision is integrated into the professionalism of their task. Supervision is quite unusual in medicine, with only occasional GPs and some medical psychotherapists using the method. It should be clearly differentiated from Medical Council compulsory supervision of a doctor who has been unwell or has been the subject of disciplinary procedures, in which supervision has administrative and regulatory connotations. In contrast, the GPs in this research use supervision on a voluntary basis for professional support and clinical development. While educative mentoring could be a more apt or descriptive term, the word supervision is used throughout this report, as it is the expression the respondents themselves continue to use.

This chapter is a brief overview of this thesis, showing the relationships between various topics and each chapter. Chapter 2 outlines supervision in a broad generic context, looking at the doctor as one of a number of helping professionals, whose task is the service of others. Using this framework, the stresses and particular exigencies of being a helping professional are identified, with supervision being chosen in some professions as the method of professional support, education and licensure. Previous research into supervision is then reviewed, and it is not surprising that there is very little research in the medical field. This chapter sets the scene then, in terms of the generic context of supervision in the helping professions, in which by contrast, supervision or other forms of mentoring relationships are relatively absent in medical culture.

Chapter 3 (philosophy) provides a further context. This is the history and underlying philosophical assumptions of modern medicine. These are elaborated at length, as general practice as it now appears, did not suddenly emerge in isolation. The main form
CHAPTER 1: Introduction

of medicine employed by GPs in New Zealand is biomedicine, with its particular history and epistemology. Biomedicine is outlined in detail, giving rise to an understanding of the anomalies in practice that prove particularly troublesome to the GP. This leads to a review of the contribution of the science historian Thomas Kuhn (1996), whose seminal book outlined how scientific paradigms evolve over time. Various contributions to medical thought are listed, illustrating the evolving conceptual basis to modern clinical practice. This includes a brief overview of a social constructivist medical model.

A review of the culture of general practice is next, in which some practitioners are suffering from low morale and burn-out. My experience as an educator in the medical school in the last four years has given me a unique opportunity to review various epistemological approaches to the patient at different stages of professional development, and these perspectives are included. This section includes a report on an educational meeting about supervision (or mentoring, as it was called), which highlighted the conceptual and philosophical difficulties of medical understanding of supervision.

Chapter 4 provides a detailed outline of the qualitative research method used. How the data from interviews were analysed is outlined and presented at length. This fulfilled several requirements. Firstly, this form of research is in stark contrast to more traditional methods of quantitative research such as randomised controlled trials, and so the details of the method need to be outlined explicitly. Secondly, the results and discussion only emerged as part of a rigorous approach to data gathering and analysis in this emerging qualitative paradigm, where the individual steps can be audited and if necessary, repeated. Thirdly, paying attention to both content and process of this research is consistent with the social constructivist paradigm outlined in Chapter 3.

An introduction to the results is provided in Chapter 5, with each participant being introduced separately, using a schematic outline of their experiences of supervision. The process of arriving at the final arrangement of themes and topics is also presented, drawing the reader into the various issues that follow. It may be helpful for the reader to use Figure 5.10 (the outline of general themes and topics, page 82) as a working map of
the results. Chapters 6 to 9 outline these results, using quotes from the participants under various headings. There is discussion at the end of each of those chapters. Chapter 9 ends with a working definition of supervision in general practice (page 202). Although these chapters are quite long and complex, they need to be considered in their entirety as a model of how supervision can change the style and culture of clinical practice.

Chapter 10 (Validity and transferability) is concerned with the validity of the presented data, with in-depth discussion on quality of interviewing, personal bias, and the concept of "the social construction of findings". It is only after such considerations that discussion can proceed on the possibility of transferability of the findings to other contexts.

Chapter 11 continues with discussion initiated in the four chapters of results. This now leads away from the specific issues generated by these respondents into more general and philosophical considerations about the place of supervision in medical practice and its outcome for the patient, for the doctor, and for the culture of general practice. This chapter includes various sections on the implications of the findings. The links between theory, practice and research are made, where both this research and the supervised practice of medicine can be seen as worked examples of a social constructivist medical paradigm.
CHAPTER 2: Supervision in the helping professions

2.1 Introduction
Supervision is a relatively unusual concept in medicine. It is however, a well-developed method of professional development and support in other helping professions (Leddick and Bernard, 1980). This chapter uses that experience to set the scene for this research about New Zealand GPs who use supervision. The chapter starts by looking at the stress of work and the need for support for the helping professional. Various models of supervision are then outlined, leading to a section on learning as part of the purpose of supervision. The final section in this chapter reviews previous research into supervision.

2.2 Stress in the helping professions
In a helping relationship, the focus is on someone else’s needs. This creates some tensions and pressures on 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, sometimes leading to burnout (Bennet, 1987; Dunst, Trivette and Deal, 1988; Payne and Firth-Cozens, 1987). This applies across the entire spectrum of helping professionals, from social workers, to counsellors, to psychiatrists, to general practitioners. A generic outline of the mechanisms of stress in the helping professional is shown in Figure 2.1 (adapted from Hawkins and Shohet, 1989, page 18).

As outlined on the next page, the helping professional juggles many pressures in his/her quest to be of service to others. The training culture and work roles may be imbued with competitiveness and non-collaboration, leading to feelings of isolation and lack of support. There may be pressure from the organisation on workers to be always in control, to be competent at all times, or not to show signs of weakness. Patients or clients may be demanding, ungrateful, unrealistic and en masse, incessant. Home or personal relationships may be a source of succour or can contribute to increasing stress. The background personality and family-of-origin issues contribute to each professional’s way
of coping, while support may come from within the organisation or be found in other places.

**Figure 2.1. Stress in the helping professional**

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<td>Successes and failures</td>
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**Maladaptive responses to stress**

- Cynicism
- Anxiety
- Isolation
- Feelings of hopelessness
- Depression
- Suicide
- Burn-out

**Adaptive responses to stress**

- Finds support
- Changes work requirements
- Reviews expectations on self
- Learns from situations and mistakes
2.3 The focal conflict model

The outline of work-related stress above can be seen as an example of a focal conflict (French, 1952; Whitaker and Lieberman, 1965). Each focal conflict includes a disturbing motive or force, matched by a corresponding reactive fear, which can prevent action or resolution of the immediate dilemma. The solution to this can be either restrictive or enabling in character. A “restrictive solution” is directed primarily at alleviating fears and does so at the expense of satisfying or expressing the disturbing motive. An “enabling solution” is directed toward alleviating fears and at the same time allows for some satisfaction or resolution of the original problem (Figure 2.2.)

![Figure 2.2. The focal conflict model](image)

For example, the helping professional in Figure 2.1 has a number of ongoing focal conflicts; his/her responses to those can be maladaptive (restrictive solutions) or adaptive (enabling solutions). Another slant on this came from Erickson (1971), who viewed individual growth as being a series of developmental crises; each crisis may or may not be resolved. Similarly, combining the symbols for “danger” and “learning” makes the Chinese symbol for “crisis”. In any stressful situation or focal conflict there is the
possibility of learning and growth, but there may be perceived danger (or barriers) to the enabling solutions. All of these considerations require a critical appraisal of the particular role of the individual at the time (role theory) in relation to the wider group or community (sociometry).

2.4 Role theory and sociometry
It can be helpful to identify an individual role at any moment in time. A role is always in relation to others, and its description includes how the person is functioning in a specific situation, with reference to the other persons or objects involved (Logeman, 1999; Moreno, 1977). For example, the relationship of a general practitioner to the wider medical community involves a consideration of the role of the individual and how the group functions as a system. Sociometry is the study of how these relationships interact to form the integrated functioning of a community (Logeman, 1999). The importance of sociometry to this thesis is that it provides a framework for understanding the pressures on GPs and how they conform (or resist) the cultural and sociological imperatives within their profession.

2.5 Responses to work stress
Now that these terms above have been defined, the responses to work-related stress can be outlined. Choosing to work in one of the helping professions is not a quirk of fate. Motives for this decision can be complex and often poorly understood, and the role of the helper implies that there is a "helpee", or someone else needing assistance. While on the surface this is obvious, there are hidden issues of power between the helper and helpee, and as well, the underlying needs of the helper may not be obvious. It is the denial of those needs and lack of awareness of power issues that contribute to helper stress and burnout (Hawkins and Shohet, 1989; Revel, 1995; Vaillant, 1965). However, the helping professional may find sources of support that enables both personal and organisational change. She may develop methods of learning from stressful situations, so subsequent events can be responded to in different ways. These would be enabling solutions to certain conflicts, such as the juggle between work and family responsibilities.
CHAPTER 2: Supervision in the helping professions

In all professions however, there are blocks and barriers to getting the support that workers need. These range from previous negative experiences of teaching or other learning situations, personal shyness, defensiveness or feelings of being judged, difficulties in finding a suitable support person, organisational barriers, and practical issues such as time, cost and travel. A further major barrier can be the culture of a profession, where in some instances asking for support implies being incompetent, needy or emotionally unstable. The particular blocks and barriers encountered by GPs in this study will be outlined later in this thesis.

Despite considerable knowledge of how stress can lead to illness, and even further knowledge of the mechanism of disease, medical practitioners are no exception to these issues. There is now considerable literature that confirms how poorly medical practitioners as a profession cope with these issues, and the rates of depression, anxiety disorder, substance abuse and even suicide are reported to be higher in the medical profession than in the general population (O’Hagan and Richards, 1997). Despite such published work, many doctors continue to work in “professional isolation”, as if they were immune in some way, to these issues.

This thesis is about supervision, one of the more enabling solutions to work-related stress. Supervision is used by a number of the helping professions, but at present the concept is unusual in medicine. This may be due to certain cultural factors in the medical profession, that together make up a significant “reactive fear”, preventing further uptake amongst practitioners. The two steps to getting supervision (or other forms of support) involve firstly, an awareness of one’s needs and of the work difficulties, and then secondly, an ability to work through the cultural inhibitions of the profession. One of the key issues here is the concept of the “good enough” helper.

2.6 The “good enough” helper

Winnicot’s concept of the “good enough” mother (Winnicot, 1965) is a helpful analogy about the construct of supervision. The good enough mother is held and supported by the
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father (or another adult) when the child is difficult and needy. As Hawkins and Shohet (1989) point out, she does not “sink under feelings of inadequacy or guilt”, but by being held herself, can hold the child even if he or she “needs to express negativity or murderous rage” (page 3). 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, with educational and organisational back up as well. Because of these issues, many helping professions now use supervision as the preferred system of providing this support.

For example, an experienced counsellor was struggling with a difficult suicidal patient “whose relentless negativity frequently drove her to despair” (Moore, 1991). She was able to express her own feelings in supervision where “it was invaluable to have a supportive arena for such discharge, in terms of my being able to stay with the client.” In medicine there are many such “difficult” patients. Restrictive solutions could be to become offhand, cynical, to blame the patient, or more commonly perhaps, to refer to other professionals. Creative solutions could involve self-understanding of why those patients in particular are problematic for that particular doctor (Wilson, 1996). By working through those feelings and issues s/he can eventually become more effective for that patient. How the respondents in this research used the supervisor for their own “difficult” patients will be presented in detail in the results.

This chapter so far has been a brief review of the issues leading to the use of supervision in the helping professions. What follows now is an overview of supervision itself, using generic principles.

2.7 The process-centred approach to supervision

There are a number of different styles of supervision. Hunt (1986), for example, described three distinct approaches when a helping professional goes to talk with a supervisor, either about individual cases or about professional development. Approach 1
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is case-centred, where the focus is on the patient's details, and what to do. Approach 2 is more helper-centred, with a focus on the ideas, interventions, feelings and processes of the professional helper. Approach 3 is interactive, focusing on the helping relationship and the interactions between the helper and supervisor. (Hunt, 1986).

Using this framework, it becomes apparent that most medical advice to the practicing doctor is in a case-centred approach (Approach 1), usually exclusively dominated by the content of the consultation, with no reference to the relationship between the referring doctor and the patient. For example, if one discussed a cardiology patient with a more experienced physician, the focus would be entirely on the patient's details, with any reference to the doctor-patient relationship being seen as inappropriate or intrusive.

Helper-centred approaches (Approach 2) to supervision are uncommon in medicine, although vocational training for general practice has built on the work of Balint (1956) and Neighbour (1987), where a focus on the reactions and feelings by the learning doctor to certain patients is becoming more legitimate. The closest model to Approach 3 in medicine would be personal counselling or psychotherapy, but this would be in a non-work setting. The model of supervision used in this thesis was first suggested by Ekstein and Wallerstein (1972), and has been further developed by Heron (1974), Hawkins and Shohet (1989), and later by Williams (1991, and 1995). It is an integrated model of all three of Hunt's approaches. The emphasis includes a consideration of all the interactions between patient and helper, and helper and supervisor. To focus entirely on either the patient or the helper would be to miss an important feature of the system of supervision, in which the relationship between patient and helper may emerge in the supervisory session. The style of supervision used by the respondents in this report will be presented in the results, with a detailed analysis of the process of GP supervision at the end of Chapter 9.
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2.8 A social constructivist approach to supervision

When the doctor discusses a patient with his or her supervisor, he/she "brings" the patient in some way into the room, by way of description, narrative and even the affect of the doctor. Different doctors would have different interactions with that particular patient and would tell different stories of their interaction, so the doctor's version is only one of many possible descriptions of that patient. There is an inevitable subjectivity to the doctor's story even if the patient has unalienable medical facts. This implies that there is no "real truth" about the patient, only the doctor's version of truth. The underlying philosophical assumptions of supervision tend more then, to social constructivism, where a relative truth emerges as part of a mutual construction between participants (Gergen, 1986). This particular philosophical stance will be discussed more in the next chapter.

What has not been discussed so far is the assumption that those who use supervision (the supervisees) are in fact learning from their experiences of supervision; otherwise it would not be a worthwhile thing to do. After a supervision session, the doctor "takes" the supervisor back into the consulting room to that patient, and incorporates his/her learning into subsequent consultations. If this were not the case, there would be little point in having supervision. Different styles of learning in relation to supervision are outlined in the next section.

2.9 Learning styles

Supervision is an example of a "reflective practice", where the practitioner observes, and later thinks about various activities and experiences. According to Kolb (1984), learning takes place in a four-stage cycle; this starts with concrete experiences followed by observation and reflection. These in turn lead to the formation of abstract concepts, which can lead to hypotheses to be tested in future action. Theoretically, learners spend time at each point in the cycle. In practice however, most people do not reflect on their experiences in great detail. General practitioners are no exception to this, going from patient to patient, day after day, week after week, and so on, without structured time to process and learn from their interactive experiences. Persons also differ on their
preferred learning style, with some tending to spend more time in one or other of the four points of the cycle (Figure 2.3).

**Figure 2.3 The Learning cycle**

![Diagram of the Learning cycle](image)

(Adapted from Kolb, 1984).

Learners can be identified as being an assimilator, accommodator, converger, or a diverger, depending on their preferential style of learning (Smith and Kolb, 1985).

Supervision can help practitioners spend more time on areas of the learning cycle that they are unfamiliar with, helping them to have more flexible learning styles. Further, as Polanyi (1958) proposed, critical self-reflection is necessary for practitioners to become consciously aware of their underlying assumptions of their profession, which in turn helps them to adapt to the demands of working life.

To summarise this chapter so far, supervision is a generic concept in the helping professions in which the good enough helper is held and supported within the supervisory relationship. Using reflection (as part of the learning cycle), the helping professional can identify his/her role in relation to others. The supervisor and supervisee work together to construct solutions to difficult situations in the work environment. This background on
supervision and learning will help to ground the results of this research into established theory. The next few sections outline previous research efforts into supervision.

2.10 Research on supervision in medicine

In the context of research into GP supervision in New Zealand, this thesis appears to be the first specific research in this area. Searching world literature with the usual medical databases (Medline, for example) was unhelpful as “supervision” as a search term was usually associated with overseeing a medical condition in a patient. “Mentoring” as a search term, gave more references, but most of these were in nursing, although there were some references to female medical practitioners using a mentor. “Professional development” was a useful keyword, but overall the medical literature is dominated by references to “looking after others”, rather than the focus being on the practitioner him/herself.

In New Zealand in the late 1990’s, Parkinson initiated a “mentoring network” for GPs in the upper North Island, where senior psychotherapists acted as supervisors for rural and urban GPs. This initiative was different to the research in this thesis as the doctors involved were recruited, rather than initiating supervision for themselves. His initial survey findings of the supervisees in this scheme were that they found it to be helpful in dealing with recent managerial changes to general practice (Parkinson, 1997), and further research is planned for the year 2000 (Parkinson, personal communication).

Freeman (1998) initiated a similar scheme in the UK in the 1980s, in response to what she described as “increased accountability with decreased professional autonomy” after the health reforms of the Thatcher government. Freeman was an educational advisor attached to the Department of General Practice in Guildford, and the mentor-project enrolled twenty-five mentors and sixty-eight “mentees” to work together 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.
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This included “education, personal support and professional development” of the mentee (Freeman, 1998).

The main theme reported in Freeman’s action research was “achieving change through the medium of a reflective, supportive mentor relationship, resulting in changed perspectives and re-ordering of priorities”. This included “learning to care for oneself ... and attitudinal change” (Freeman, 1998, page 459). With similar pressures on health professionals here in New Zealand in response to continual health restructuring, it would be surprising if there is not a similar mismatch between accountability and autonomy, with inherent stress on the professional. However, schemes such as Freeman’s are relatively uncommon, where the emphasis combined education about GPs’ work, as well as personal facilitation leading to professional development.

2.11 Supervision research in other professions

There was a large body of literature on supervision in the counselling and psychology fields, as well as in marriage guidance. Specific research on supervision in these fields was more often by surveys rather than by interviews, but there were many case reports as single articles in journals such as Journal of Counselling Psychology, The Counselling Psychologist, or the Clinical Supervisor. Books already mentioned such as Williams (1995) and Hawkins and Shohet (1989) gave many examples of experiences of supervisees and supervisors as part of their development of the concept of supervision, and so these represent de facto examples of “experience-orientated” research.

Descriptions (as opposed to research) of the supervisory process in other professions were quite common. Schainberg’s sensitive review of the emergence of inter-subjectivity in the supervisee was one of the better descriptions of what actually happens in the supervision room (Schainberg, 1983). This was in stark contrast to some of the studies in psychology journals, which tend to be more behaviourally focused using rating scales (Worthington and Roehlke, 1979), or advanced mathematical analysis (Rabinowitz, 1986). A good example of this genre was Friedlander, Siegel, and Brenock (1989), who
studied parallel process in supervision by following a client-therapist-supervisor system over eight consecutive weeks. Their method was to use about a dozen research "instruments" (for example, personality inventories, session evaluation questionnaires, or verbal response categories) to analyse what had happened each week between the client and therapist and between the therapist and supervisor.

Doehrman however, had already established the importance of parallel process in her superb original work in 1976. She studied eight systems of client-therapist-supervisor. After each therapy or supervisory session she interviewed all the participants with open-ended interviews over a period of twenty consecutive weeks. In the interviews the emphasis was on "process" rather than on "outcomes." She looked for data on the current therapeutic situation, the therapist's feelings about the client and about the supervisor, the supervisor's review of the current supervisory situation and his/her feelings about the trainee. Her emerging hypotheses were verified by audio-tape review of both therapy and supervisory sessions, and by checking each week with her protagonists. In this way, validity was built into the research process (Doehrman, 1976).

She found that all the therapists had intense interpersonal reactions to their supervisors (called transference) and that their key issues were acted out, not only with their supervisors, but also with their clients. When transference problems were resolved in supervision, then any impasse in therapy seemed to also change, with the therapists becoming more open and responsive to their clients. Similarly, if the therapist was resisting the help or advice from the supervisor, there would be a concurrent difficulty in therapy, where the client would be resisting the efforts of the therapist to effect any change.

This type of in-depth, extensive data collection of the client-therapist-supervisor system has not been repeated to my knowledge. It raises crucial issues about the place and importance of the supervisor as a way of monitoring any therapeutic relationship, and one can only speculate about the course of therapy in the absence of supervision, when the
CHAPTER 2: Supervision in the helping professions

therapist’s counter-transference remains unexamined. One of the purposes then, of supervision, is to critically inform the helping professional of issues in the therapeutic relationship, by providing a forum where they can be acted out and commented on. While supervision is uncommon in medicine, the concept of parallel process is totally absent. The idea of a GP ringing a consultant about a patient, for example, and subconsciously acting out some of the difficulties in the GP-patient relationship, would be a quantum leap for most medical practitioners.

2.12 Summary

Many helping professions (for example, social work, psychiatry, or marriage guidance) include supervision as an integrated systemic approach to helping. This has not been the case in medicine however, and the reasons for this will become apparent throughout this thesis. This generic overview of supervision gives the language for an extended discussion about the general practice model of supervision. The GPs in this study who are using supervision constitute an outlying group from mainstream medical practice.

Advocates of supervision are very clear that it is a worthwhile thing to do (Dryden and Thorne, 1991; Hawkins and Shohet, 1989; Neufeldt, 1995; Williams, 1995). While the “outcomes” for the patient (from the helping professional having supervision) are difficult to quantify, I agree with Hawkins and Shohet in their “commitment to truth”. They talk of the danger of the “small daily self-deceptions that destroy people’s respect for themselves and each other”, and their method of confronting these is through the quality of the human-to-human relationship in supervision, without which “the work with clients is incomplete” (page 156).

It is difficult to present these issues and concepts to a largely medical audience as most doctors have little appreciation of supervision as described here. For this reason I have given a reasonably full account of supervision, which precedes the rest of the thesis. The next chapter locates this research into the context of the history of medicine and the
CHAPTER 2: Supervision in the helping professions

culture of general practice. These considerations may provide the reasons for the relative scarcity of supervision in medical culture.
CHAPTER 3:
The philosophy of medicine and the culture of general practice

3.1 Introduction
Having reviewed the literature on supervision in the helping professions in general, this chapter now locates this research into further contexts. Firstly, general practice is embedded within the history and philosophy of western medicine. This means that there are a number of assumptions about the thought processes in medicine and about certain ways of practice that need to be articulated explicitly before the results of this research can be interpreted. Secondly, qualitative research at present sits rather uncomfortably in this historical context and the reasons for this will become apparent shortly.

If medicine is imbued with a nomothetic methodology (see Appendix 5; Glossary of terms) it places considerable tension on practitioners, who are then required to combine both a science of disease with an art of interacting with individual patients. Criticism from Hayek (1979) and Toulmin (1993) that medicine “masquerades” as an objective science is discussed, with various responses being postulated. One of these is that medicine is in a “paradigm crisis” at present, using the definition of paradigm espoused by Kuhn (1996). Briefly, the current medical paradigm crisis has arisen in response to certain anomalies in medical practice in the twentieth century. Several alternative models of medical science have been developed since the 1950s, with “patient-centred medicine” (Stewart et al, 1995) emerging as one of the challenges to the traditional paradigm of biomedicine.

General practice in New Zealand is embedded in this complex history of Western medical development. The subjects of this study using supervision are located in this history, and the findings of this thesis have particular implications for the culture of general practice. These considerations are an important background for this thesis. When the respondents here talk about their work, it is in the context of the theoretical models they were given as undergraduates, contrasting with the difficulties of their clinical work as mature GPs.
The resolutions to these conflicts form the basis to some of the results. Firstly however, biomedicine is defined at length, using a clinical example.

### 3.2 Biomedicine as the predominant medical paradigm

The first consideration about the nature of western medicine is to view it as a paradigm of practice. A paradigm is a set of overarching interconnected assumptions about the nature of reality within a given scientific community; a basic set of beliefs that provide coherence to one’s picture of the world (Kuhn, 1996). In medicine, the current predominant paradigm is biomedicine. McWhinney (1983) has defined biomedicine as follows:

*Patients suffer from diseases, which can be categorised in the same way as other natural phenomena.* A disease can be viewed independently from the person who is suffering from it and from his or her social context. Mental and physical diseases can be considered separately. Each disease has a specific causal agent, and it is a major objective of research to discover them. Given a certain level of host-resistance, the occurrence of disease can be explained as a result of exposure to a pathogenic agent. The physician’s main task is to diagnose the patient’s disease and to describe a specific remedy aimed at removing the cause or relieving the symptoms. He or she uses the clinical method known as differential diagnosis. Diseases follow a defined clinical course, subject to medical interventions. The physician is usually a detached neutral observer, whose effectiveness is independent of gender or beliefs. The patient is a passive and grateful recipient of care.

(Adapted from McWhinney 1983, page 4, emphasis added.)

This is a fairly accurate description of the orthodox version of twentieth century medicine, which has a narrow biological focus. By definition, personal, social and cultural factors are considered irrelevant to the problem for each patient, and treatment is
recommended solely on diagnostic conventions. The usual history-taking format (which includes past medical history, review of systems and so on) is more correctly a disease inventory for that person, as there is usually little emphasis on the patient's narrative story (Greenhalgh and Hurwitz 1999; Hunter, 1991).

Biomedicine is now taught explicitly in western Universities and has been the main form of medical intervention since the latter part of the nineteenth century. While it could be argued that many doctors do use a broader medical model in actual practice, biomedicine is still the predominant discourse in most medical journals, almost all textbooks of medicine, in hospital grand-rounds, in referral letters, in grant applications, in management, and so on.

The definition contains several implicit assumptions. The first assumption is that disease can be considered as separate to the person with it, like other naturally occurring phenomena, implying that apart from the doctor's biological interventions a disease will continue to run a well-defined course, quite independent of the patient's context or beliefs.

Secondly, the inherent logic is one of simplistic cause-and-effect: substance A will act on substrate B, causing effect C. For example, a bacteria acts on the host, causing a specific disease. Thirdly, the doctor is expected to remain distant to the patient, rather like a natural scientist. This implies that the interaction between doctor and patient would have no influence on the outcome of the disease. The "detached observer" is a well-known phrase that describes this correct approach to the patient. This goes back as far as Sir William Osler, one of the most influential medical leaders in the twentieth century and famous for his inspirational lectures. For example; "No quality ranks with imperturbability... Cultivate then, gentlemen, such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage" (Osler,
1932). This was the form of medicine taught in medical schools throughout the twentieth century, yet the underlying epistemology has never been articulated explicitly.

### 3.3 A clinical example

Brohm’s autobiography about her breast cancer included an account of her hospital experience (Brohm, 1986). At first she did not want the offered mastectomy.

*His management of my crisis consisted of a pat on the hand and the assurance that he was very sorry. I was pretty sorry myself. This was the ultimate existential crisis and it packed a terrific punch. My medical team were dealing with a diagnosis as a physical problem in terms of their personal and technological resources, while I was trying to handle it on a mental and emotional level as a spiritual challenge.*

*It seemed incredible that whatever attention had been afforded to me generally was now withdrawn, and instead focused exclusively on my left breast. Doctors, studiously avoiding eye contact, came, examined me and left. Risking the agony of deep exposure, I asked to see the doctor who seemed to have played the role of chief negotiator. He arrived, briskly pleased, imagining no doubt that I had finally come to see things his way [to consent for mastectomy]. “I think I know why I’m ill,” I announced. I was absolutely shattered by his exasperated reply. “Well, that doesn’t make any difference to the way we treat you,” he said.*

*I understand much better now how tightly some people are welded to a mechanistic model of disease that make such attitudes entirely predictable. However my refusal to accept the preferred mastectomy so infuriated the doctor that he terminated our discussion by sweeping away the curtains that surrounded my bed, firing as his parting shot over his shoulder; “The decision will obviously have to be taken out of your hands”. Unfortunately I was only too well aware of*
the prognosis for a middle-aged woman with breast cancer: somewhere round 80% chance of surviving five years. [Later] I asked the doctor what I could do to help myself. To put myself in the winning half of the statistics. "Nothing," he replied. (Brohm, 1986, pages 6-7).

What has happened here? Why were this doctor and his patient unable to communicate effectively or to hear each other's point of view? It could be argued that this was simply an inadequate bedside manner, or a clumsy attempt at obtaining compliance (to mastectomy). Yet that argument trivializes the communication divide between patient and doctor, who seemed to hold different world-views. Surely both protagonists had similar goals, so how could such discord occur? The patient had personal and even idiosyncratic ideas about causation and treatment, while the doctor's single purpose was to treat the disease by mastectomy, regardless of the patient's ideas. He must have had good reasons to be so dogmatic; perhaps the reason for their discord was the unstated philosophical basis of orthodox modern medicine.

3.4 Philosophical definitions

Two attempts to be more explicit about the philosophical basis of biomedicine follow.

Little (1995) was a retired surgeon with an interest in medical ethics

It is sufficient to say that western medicine has evolved very strongly in a tradition of empiricism, realism, materialism and positivism, and for these reasons the scientific or experimental method is highly valued by medical scientists. (Little, 1995, page 31).

Mattingley's (1988) view of biomedicine was from an anthropological viewpoint.

Biomedical professionals attempt to deploy a means-end rationality directed to controlling the disorder created by illness. The reasoning process is justified by
The empiricist and essentialist understanding of reality and the belief that the ultimate reality one is dealing with is biological...medical professionals commonly assume that clinical reasoning is a form of implied natural science. (Mattingley, 1988, page 275).

The “natural science” referred to here has been imbued with this objectivist and positivist philosophy, which was initiated in the seventeenth century with contributions from Descartes, Newton and later Compte (Ryan, 1998). Table 3.1 (next page) compares the philosophical opposites of objectivism and subjectivism. From the table, it appears that biomedicine is located firmly in an objectivist philosophy. Briefly, realism and nominalism are two ends of the spectrum in ontology. The realist view in traditional science is that all objects have an independent reality and meaning quite separate to the observer. If knowledge pre-exists and “needs discovering”, then the researcher is required to be in an observer role. However, if knowledge and meanings are cultural, personal and unique, then the researcher needs to be more involved to find those meanings. Determinism and voluntarism are also polarised opposites in the scale of views about human behaviour. The growth of behaviourism in the 1950s, for example, illustrated the prevailing view that human beings respond in a mechanistic way to challenges from their external world. Similarly, the researcher in an objectivist paradigm looks for universal laws, which are true in all situations; the methods are said to be nomothetic. However a research method designed to understand individual human behaviour would be called idiographic. Current definitions of these terms are listed in Appendix 5.
CHAPTER 3: The philosophy of medicine and the culture of general practice

Table 3.1 Comparisons between objectivism and subjectivism.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Postulates of objectivism</th>
<th>Postulates of subjectivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the world work? (Ontology)</td>
<td>There is only one reality. By carefully dividing and studying its parts, the whole can be understood. (Realism)</td>
<td>There are multiple realities, being socio-psychological constructions forming an interconnected whole. (Nominalism)</td>
</tr>
<tr>
<td>2. What is the relationship between the knower and what is known? (Epistemology)</td>
<td>The knower can stand outside of what is to be known. True objectivity is possible. (Positivism)</td>
<td>The knower and the known are inter-dependent.</td>
</tr>
<tr>
<td>3. What role do values play in understanding the world?</td>
<td>Values can be suspended in order to understand.</td>
<td>Values mediate and shape what is understood.</td>
</tr>
<tr>
<td>4. Are causal linkages possible?</td>
<td>One event comes before another and can be said to cause that event.</td>
<td>Events shape each other. There are multidirectional relationships.</td>
</tr>
<tr>
<td>5. What is the possibility of generalisation?</td>
<td>Explanations from one time and place can be generalised to other times and places</td>
<td>Only tentative explanations for one time and place are possible</td>
</tr>
<tr>
<td>6. Human nature</td>
<td>Determinism</td>
<td>Voluntarism</td>
</tr>
<tr>
<td>7. Methodology</td>
<td>Nomothetic (search for universal laws)</td>
<td>Idiographic</td>
</tr>
<tr>
<td>8. Preferred method of research</td>
<td>Quantitative research</td>
<td>Qualitative research</td>
</tr>
</tbody>
</table>

(Adapted from Maykut and Morehouse, 1994.)

In McWhinney’s definition (1983) of biomedicine, health professionals appear to use an objectivist philosophy, with a positivist epistemology. These scientists would search for universal truths; in this case the truths are about the nature of disease. Reviewing the clinical vignette about Mrs. Brohm, the doctor seemed to believe that not only were her
ideas on causation irrelevant, but that she was powerless to influence her outlook in any way. His underlying view of the human condition tended to an almost fatalistic determinism, while his ontological view was that diseases were real entities independent of the person with it. The contradiction with his epistemology was however, quite striking. Far from being a detached observer, he was clearly quite passionate about his view of disease, and found it extremely annoying that his patient was less than a grateful and passive recipient of care. In fact, he was very much involved, but in a paternalistic way.

Defining the philosophical assumptions in that example has demonstrated the difficulty of applying the ideology of medical science to the individual patient. Can disease, for example, be considered as a separate thing to the person with it? Can the behaviour of disease in one patient predict how it will appear in another? Is the same disease consistent across cultures? Is disease a universal law, in the same way that gravitation, say, is a function of the universal laws of physics? The answers to these questions will be considered following a brief review of how students become enculturated into this predominant medical paradigm.

This objectivist approach to medical practice starts in medical school (Sinclair, 1997). Students learn about anatomy, cell biology, physiology or pharmacology, and it seems that this particular knowledge is reasonably independent of context. They then learn about diseases using the same methodology (detached observer, generalisable laws independent of context, and so on), and so over the years, students are gradually inculcated with an objectivist or positivist stance. As emerging doctors, this places them in a rather difficult position. How are they to approach the real patient, who contains all that physiology and anatomy, and one of those diseases? It would be not unreasonable for them to consider this new “object of study” in the same way, as they have never been explicitly taught anything different.
3.5 Criticism of this epistemology

Hayek (1979) has been one of strongest critics of modern medicine. He coined the term "scientism", which is an insecurely based belief that the methods and the philosophy of the natural or physical sciences can be applied to the social sciences. He implied that medicine is really a subjective science, masquerading as a hard objective one (Hayek, 1979). His words constituted an important challenge to modern medicine, embedded in a 300-year history of nomothetic science. Sorell (1991) similarly criticized the twentieth century's uncritical infatuation with science.

The first possible response to these critics could be that medicine is both subjective and objective at various times, and that an argument over such a polarised distinction is unnecessary. Little (1995) held this view, but it did not answer the question of when one should tend to subjectivism or objectivism in Table 3.1. Simplistically, one could say that in search of knowledge the doctor should be objectivist, while in the practice of medicine (the art) s/he should be more subjectivist. Yet often in practice this does not occur; certainly it did not happen for Brohm. Similarly, the recent trend toward biological psychiatry implies that practitioners believe more in a deterministic view of human nature, than in seeing man as creator of his actions and behaviours. Those beliefs would strongly influence the management of patients with psychological problems, and so the direction of the consultation would once again be philosophically led.

A second possible response came from Toulmin, who elaborated further on this paradoxical combination of the art and the science in medical practice. In his words, medicine "presents philosophers with a peculiarly rich and close alliance of mind and hand, theory and practice, universal and existential" (Toulmin, 1993, page 231). His criticism of the overly objective doctor was particularly severe, echoing the reservations of Hayek and Sorell.
The misplaced emulation by physicians of ‘science’ is...the real reason why the general public is alienated from professional medicine. Inevitably and properly, the focus of the natural sciences is on the general rather than the particular, the universal rather than the existential...So instead of seeing individual subjects as ‘patients’ afflicted with various ills, biomedical scientists legitimately regard them as ‘cases’ of general syndromes or conditions; their subjects are therefore interesting only incidentally, to the extent that they exemplify some pathological entity that is interesting in itself. (Toulmin, 1993, page 234).

His resolution of this (and also of Hayek’s position) was to refocus back to the original goal of medicine; to relieve suffering in the individual patient.

Medical knowledge can make no pretense at being a general and universal [knowledge]; rather it is intrinsically a variety of particular, existential knowledge... The proper application of general medical knowledge to individual human beings demands an accurate application of their particular needs and conditions; so that the task of medicine - however ‘scientific’ it may become - remains fully ethical. (Toulmin, page 237).

This second possible response to “scientism” then, is to return to the original goal of medicine, seeing both art and science as legitimate factors intersecting in the mind of the attendant physician, who has taken the history from the patient and who can interpret it within his more general knowledge. According to Toulmin, the myth of medical science this century has been in erroneously applying an uncritical objectivity to individual patients.

A third response to Hayek is slightly more complicated. This involves “normal science”, “anomalies”, and “paradigm revolutions” - all of which are derived from the work of Thomas Kuhn.
3.6 Kuhn and the history of science

Thomas Kuhn was an historian who researched the history of science for his Ph.D. at Chicago University. His conclusions were eventually published as "The Structure of Scientific Revolutions", with the first edition in 1964 being one of the more influential books in the twentieth century (Kuhn, 1996). While Kuhn himself did not explicitly use medicine in his examples about the history of science, his model of paradigm change could be a third response to Hayek's criticisms of biomedicine.

Kuhn's thesis was that scientific communities have periods of normative consensus when practitioners agree about the underlying important assumptions of their science, to the extent that they become implicitly accepted rather than debated. The assumptions are about the nature of the world (ontology), about the relationship between the observer and the observed (epistemology), about what is acceptable logic, and about acceptable methods of investigation. Scientists in the paradigm perform "normal" research, which confirms rather than challenges those assumptions.

Normal research in medicine is exemplified by the randomised-controlled trial (RCT). This is based on a linear cause and effect logic, to evaluate the effect of one variable while other extraneous effects are excluded. As Little (1995) said, "the controlled trial has been the gold standard of clinical research for 50 years" (page 40), despite the limitations of transferability to (uncontrolled) clinical reality. By designing a RCT, the experimenter is usually complying with all the injunctions of positivism, and so it is unlikely that results obtained will challenge the assumptions of the biomedical paradigm.

Similarly, most medical journals will only publish objectivist (or normal) research, although there is an emerging school of qualitative research within the medical context (Britten and Jones et al., 1995; Chapple and Rogers, 1998; Murphy and Matson, 1992). The research method in this thesis has been in a qualitative paradigm. This paradigm is
unfamiliar to most medical readers, and so there is an extended description and discussion on the method in Chapter 4.

Kuhn also discussed the usual practice of a science, as distinct from its associated research, and normal medicine here is taken as the model of biomedicine, defined above with all the nomothetic and positivist assumptions.

3.7 "Normal" medicine and clinical anomalies
Just as in research, the practice of medicine usually confirms the underlying philosophical basis. Catheterisation closure of a patent ductus-arteriosis, penicillin cure of a life threatening meningitis, the chemotherapy cure of leukemia; these are examples of the normal science of biomedicine. They are consistent with an underlying objectivist view that diseases are separate entities to the person; psycho-social issues are considered to be irrelevant to causation or to the outcomes of interventions. In this way, the biological model works very well and the underlying assumptions of the predominant model do not require any discussion or challenge.

However, not all of medical practice is so straightforward. Kuhn's thesis included anomalies, in which some observations or experiences do not fit the expected pattern. Individual practitioners then have to decide how to interpret this new experience or data. Is it a chance finding, or is it from faulty observation? Or is it conceivable to challenge the underlying assumptions of the paradigm?

Are there anomalies in the practice of modern medicine? Clearly, McWhinney thought so, describing four common situations where patients (and their diseases) do not fit with the biomedical model (McWhinney 1989, pages 47-56). These are listed briefly here, and I include a fifth anomaly (the effect of patient-doctor communication.)
3.8 Five current anomalies to clinical application of biomedicine

1. *The disease-illness anomaly*. Often patients appear unwell, and present for help, but their illness cannot be assigned to a specific disease category. McWhinney called this the *illness-disease anomaly*. In other words, persons may become sick, but the biomedical model cannot explain why.

2. *The specific aetiology anomaly* demonstrates the inconsistent spread of disease across different sectors of society (and across societies), which challenges the internal causality logic of the model.

3. *The mind-body anomaly*.

4. *The placebo effect*. These two anomalies are related. Patients can have significant bodily symptoms, either from psychological stress, or from taking inert substances such as placebo. How this happens in the biomedical framework is not at all clear, and the lack of theoretical justification for these patient’s symptoms can lead to unnecessary investigations and patient alienation, when practitioners continue to seek a biological cause for the patient’s symptoms (Broom, 1997).

5. *The doctor-patient interaction*. There is also evidence now showing how the interaction between patient and doctor has a significant effect on the outcome of the consultation. (Bass et al, 1986; Kaplan et al, 1989; Kinnersley, 1997; Stewart et al, 1979; Stewart, 1995; Williams and Weinman, 1998). This is almost a violation of the positivist epistemological basis of biomedicine, (where the doctor should be able to observe without influencing what is being observed). This accumulating body of research data represents the most recent major challenge to the current orthodox paradigm, where biomedicine (as defined by McWhinney) cannot explain these observations.

What is required then, is an advanced medical paradigm that builds on the strengths of traditional biomedicine, and is able to incorporate these anomalies without causing scientific astonishment or patient dissatisfaction. The question here is: “What sort of science should underlie the practice (and the research) of modern medicine?”
3.9 What sort of science for clinical medicine?

Feinstein (1970) attempted to answer that question almost three decades ago with an important article “What kind of basic science for clinical medicine?” His proposal was to distinguish between “explanatory” decisions for the names and causes of diseases, and “managerial” decisions for therapeutic interventions, roughly corresponding to the “science and the art” from Toulmin. “Physicians have developed a splendid clinical science for explanatory decisions, and a magnificent technologic armamentarium of therapy, but our managerial decisions generally continue to be made as doctrinaire dogmas, immersed in dissension and doubt” (Feinstein, 1970, page 849). He compared the processes of a laboratory experiment with clinical therapy, as superficially there are some similarities. The investigator (clinician) observes the result (patient outcome) of one variable (treatment) on the subject under study (patient). Yet there are major differences. A laboratory experiment is designed around a linear cause and effect logic, while patients are at the centre of a matrix of interactive influences. Laboratory experiments are short, clinical therapy may last for years. Laboratory experiments can be repeated. Clinical therapy in the one patient is less often repeatable, as the patient and the context will inevitably change. Reproducibility or generalisability from one patient to another is at best dubious.

Despite his own misgivings, Feinstein went on to suggest that “we now need a quantification of prognosis [by] large scale clinical epidemiological studies of the cause and outcome of disease in patients.” (Feinstein, page 852). In other words, he wanted to use his explanatory science to answer the questions that his managerial science was still struggling with. He touched on the underlying ontological basis of medical science, but was unable to see past it to answer his own paradigmatic dilemma. He would have been unable to solve the “problem” of Penny Brohm using any number of epidemiological studies, and the question of what sort of science for clinical medicine remained unanswered.
Feinstein was one of many medical thinkers who have been trying to resolve this paradigmatic crisis in the last fifty years, with major contributions from Balint (1957), Engel (1977), Cassell, (1976, 1997), McWhinney (1988) and Stewart et al (1995). These contributions will be outlined in detail in the following sections, as the respondents in this research specifically locate their clinical work within these emerging models.

3.10 The Balint method

Michael Balint was a Swiss psychoanalyst who lived in London in the 1950s. He encouraged groups of British general practitioners to examine the wider lives of their patients, and to notice transference and counter-transference in the doctor-patient relationship. He developed the concept of "doctor as drug", and encouraged practitioners to notice and use their own feelings in consultations (Balint, 1957). The underlying assumption was that the style and course of doctor-patient relationships profoundly influence the long-term outcomes of illness. His work received considerable acclaim, and communication skills have more emphasis now in general practice training.

Although GPs are encouraged to join a peer group, Balint-style groups remain relatively uncommon and the latest Balint book lamented that the movement has not gained a stronger following (Balint, 1992). There are several reasons for its relative failure so far as a major paradigm. Firstly, it may be too early to assess its long-term influence. Secondly, exponents had not used quantitative methods to assess its efficacy. Thirdly, Balint's work was based on psychoanalysis, and most GPs are unfamiliar with that field of psychiatry. Finally, emphasis on the relationship between doctor and patient is well outside the parameters of the established medical model, and so there may have been too great a conceptual hurdle.

3.11 Bio-psycho-social medicine

George Engel was professor of psychiatry and medicine when he published his seminal paper in Science in 1977 (Engel, 1977). Although he had previously published his ideas
widely, this paper marked a more coherent challenge to biomedicine. He drew on a model by Von Bertallanfy, who had proposed a “systems theory” in biology (Van Bertallanfy, 1968). This had been widely accepted in other fields, such as physics, meteorology, business and sociology. In the medical field, the levels from atoms to biosphere are seen as separate self-maintaining systems. Interactive processes within each system may differ widely. Homeostatic mechanisms are explained by inertia within each level, but eventually even small changes at one level can trigger large changes at another. Engel applied the theory to the human response to illness. At a practical level, it meant that emotional and social factors would influence the presentation of illness as well as enhance or delay recovery.

Engel’s further provocative paper compared the seventeenth century paradigm of Newton and Descartes with that of the uncertainty paradigm of Einstein and Heisenberg (Engel, 1988). He quoted Heisenberg as saying “what we observe is not nature itself, but the interplay between nature and ourselves; science describes nature as exposed to our way of questioning” (Heisenberg, 1958). Engel was presenting a strong challenge to medical science; if the most positivist and realist of all sciences (physics) had already moved from an objectively verified reality “out there”, to a reality dependent on the mode of looking, then why was there a delay for medical science to follow suit?

However, while this theory (biopsychosocial medicine) is persuasive and is taught as theory at an undergraduate level in the behavioral sciences, students learn their mode of practice principally by observing their teachers in action and emulating their behaviours with all the implied assumptions of their philosophies of science. Further, Engel did not have a method of teaching his version of medicine at the postgraduate or clinical level.

3.12 Somatisation (psychosomatic illness)
This theory was developed in the 1960s, and allowed for physical expression of psychic and emotional illness without underlying biological pathology. Goldberg's Manchester
somatisation study found that up to 20% of new presentations of physical illness fulfilled all the research criteria for somatisation (presentation of physical symptoms, no physical pathology, and an identifiable psychiatric disorder present (Goldberg and Bridges, 1968). This model directly confronted the mind-body dualism that according to Cassell, has been both the strength and the weakness of modern medicine (Cassell, 1997). One of the leaders in this field has been Dr Brian Broom from Christchurch (Broom, 1997), who is both a physician and a psychotherapist. However, as he points out, doctors are no more effective for applying the “somatisation” label to their patients, as they are still limited by the dualism between mind or body, and often by the patient’s reluctance to consider any connection between these two categories.

This particular model has the potential to explain many of the anomalies, proposing that physical and emotional symptoms are simply different reflections of an underlying psychic disturbance. There is a problem here though, with nomenclature. To suggest that some patients somatise is to suggest that others do not, while psychosomatic illness is a term that could only arise from a dualistic framework. It is difficult to conceive of a fully integrated organism that presents in many ways (spiritually, somatically, emotionally, or all of these), when one's training is reductionist. As well, these patients use physical symptoms as a defense against feelings; as doctors also use similar psychological defense mechanisms, the profession would be reluctant to use this paradigm (Broom, 1997). The somatisation model is known to many general practitioners in New Zealand, but they continue to have conceptual difficulties with these patients; this will be further discussed in section 3.21 in this chapter. Some of the GPs in this thesis have been influenced directly by Broom, and their approach to somatisation will be outlined in detail in the results.

3.13 The distinction between disease and illness
Cassell (1976) made an important distinction between the illness experienced by a patient, and the disease he or she carries. This subsequently led to his reintroduction of
the importance of the patient's suffering as the central focus in medicine (Cassell, 1991). These ideas were important conceptually, as they have helped the medical professional to move away from a limited focus on the disease as the only legitimate area of concern.

When someone first experiences a symptom, he or she may find it inconvenient, annoying, terrifying, or any of a variety of feelings. S/he may have ideas about what caused the problem and will try different ways of restoring themselves to full functional capacity. Eventually, if symptoms persist, they may ask family and/or friends for help. Some eventually seek professional advice, with certain expectations about treatment. Different persons react in different ways to the same sorts of symptoms, depending on their social background and the stage in their life cycle. The meaning of the symptom (does this chest pain mean angina, or does this back pain mean secondary cancer?) will be important. How long symptoms will last and when the patient can return to work, are questions about the place of the future. All these considerations constitute the "experience of illness" for that person, and they strongly influence the course of the disease, the patient's interaction with health professionals, and their adherence to treatment (Cassell, 1976; McWhinney, 1989).

Disease on the other hand, is concerned with symptoms, signs, investigations, differential diagnosis, and treatment. The distinction between illness and disease has been one of the building blocks of patient-centred medicine (PCM).

3.14 Patient centred medicine

Using this distinction above between disease and illness, the Canadian group from Ontario have developed their model of patient centered medicine (Stewart et al, 1995). This group introduced the concept of agendas; the doctor's agenda about disease and treatment, and the patient's agenda being the illness experience for that person. Their model includes six tasks (Table 3.2). There is considerable emphasis on negotiated
understanding of what the problem is for the patient, and negotiated plans for management of that problem.

Table 3.2 The six interactive components of the patient centred clinical method

1. Exploring both the disease and illness experience
   A. differential diagnosis
   B. dimensions of illness (ideas, feelings, expectations, effects on function)
2. Understanding the whole person
   A. The person (life history and personal and developmental issues)
   B. The context (the family and any significant others, the physical environment)
3. Finding common ground regarding management
   A. problems and priorities
   B. goals of treatment
   C. roles of the doctor and of the patient in management
4. Incorporating prevention and health promotion
   A. health enhancement
   B. risk reduction
   C. early detection of disease
   D. ameliorating effects of disease
5. Enhancing the doctor-patient relationship
   A. characteristics of the therapeutic relationship
   B. sharing power
   C. caring and healing relationship
   D. self-awareness
   E. transference and counter-transference
6. Being realistic
   A. about time
   B. over resources
   C. team building

(From Stewart et al, 1995)

McWhinney has been the doyen of the patient-centred method, and along with various others has published widely (Levenstein, McCracken, and McWhinney, 1986; Stewart et al, 1995; Weston, 1988). They have further developed the contributions from Cassell and Engel into a practical model that can be measured clinically (Henbest and Stewart, 1989). Their collective influence on general practitioner training has been considerable, and of all the proposed models in the last fifty years, patient-centred medicine appears to be
mounting the strongest theoretical challenge to traditional biomedicine. Just as Kuhn proposed, this emerging paradigm could incorporate the strengths of biomedicine into a wider model, it could explain many of the anomalies, and different forms of research could become more acceptable.

Philosophically, an emphasis on the illness experience of the patient, and on negotiation of understandings and management, means this paradigm could be described more in interpretive, phenomenological, or social constructivist terms. If this were the case, then PCM would represent a significant paradigm shift for medical practitioners, if they were to use this model. The respondents in this thesis were not taught PCM explicitly, as they graduated prior to its conception. However, how their clinical practice compares to a PCM model will be outlined in results.

3.15 The problem of “incommensurability” and “paradigmatic crisis”
Kuhn’s concept of incommensurability is relevant here. Because different paradigms have different assumptions (and because these are rarely articulated explicitly), it is difficult for practitioners from different paradigms to understand the other’s way of practice. For example, Broom has been lecturing and speaking at conferences on the somatisation model for several years, and he has come to expect considerable resistance to his more integrated approach, as most practitioners find it difficult to comprehend the underlying philosophy (Broom, personal communication).

Kuhn proposed that for a time traditional and emerging paradigms compete for ascendancy, with disciples on different sides advocating their own views and being unable to understand the logic of the other. Paradigm debates can be protracted and sometimes bitter, but eventually there is resolution, and a new paradigm emerges as the dominant one. Other challenges are discarded (Figure 3.1).
With regard to the challenge of PCM to traditional medicine, the former appears to be only a subtle modification of the latter, but it does in fact represent a considerable philosophical shift. To say the patient’s story and culture is significant to the history, and to say that the outcome of illness is a negotiated course of events, is to test the assumptions of biomedicine. The Ontario group have already shifted their curriculum to PCM, and I am personally involved at Otago University in efforts to widen the focus of history taking, aiming eventually towards a change in curriculum. However, it is likely that these transitions will be marked with considerable tension, while the underlying philosophical assumptions of the models remain unexamined.
CHAPTER 3: The philosophy of medicine and the culture of general practice

These considerations about paradigms are an important background concept for this thesis, because general practice is an area of clinical work at the centre of this paradigmatic crisis. The respondents in this research will be encountering these issues on a day to day basis. It is conceivable, however, that already some practitioners in medicine are locating their work in a different paradigm to that of biomedicine, using different philosophical constructs in their professional work. What follows now is a proposed definition of a social constructivist medical paradigm. Some examples of current practice follow, where practitioners’ behaviours appear to be discordant with the principles of biomedicine and more grounded in this constructivist model.

3.16 A social constructivist medical model

patients suffer from illnesses arising from a matrix of cultural beliefs and biological systems. A complex interaction occurs between patient and clinician, and behavioral outcomes are constructed from their negotiations and the doctor’s physical interventions. Patients are accorded “sick” status according to social conventions unique to each sub-culture. Recovery from illness will depend on individual beliefs, cultural support systems for the patient, the influence and process of the doctor-patient relationship, and biological factors (Wilson, 1999b).

The underlying science here is located in a constructivist philosophy (Guba, 1990); other descriptive terms would be phenomenological (Baron, 1985), interpretivist, or subjectivist. The research methodology in this paradigm would legitimately include qualitative, narrative and interview research. These would be accorded equal validity and status with quantitative research, such as randomised controlled trials. Understanding the complexities of the decision-making process between doctor and patient would be an important focus, using methods such as video analysis (Coleman and Murphy, 1999) and building on conceptual models such as information-processing (Frederikson, 1993). This paradigm would build on the strengths of biomedicine, rather than rejecting them. The
Examples of normal medicine listed on page 30 are still valid; they can be seen as special cases of the wider medical model, just as Newton's laws of gravity are special cases of the wider model of relativity. These special cases work well, given a more narrow focus.

3.17 Medicine in a social constructivist model

There are many examples of common medical practices that illustrate an underlying philosophical tension. These include the inappropriate prescribing of narcotics to drug-seeking patients, of antibiotics for viral infections, or of hypno-sedatives in the elderly. These physician behaviors are inexplicable when viewed from a biomedical paradigm, as there is no research or biological evidence to support such actions. Yet as outcomes from a complex socio-cultural interaction (the consultation) in a social constructivist paradigm, they are readily understandable.

Variation in care between different practitioners is another example. A Norwegian study (Rethan and Saebu, 1997) exposed unwitting practitioners to standardised patients with the same medical condition. They found that each doctor varied considerably in performance with each patient, and concluded that determinants other than biomedical factors were influencing the behavioural outcomes. Similarly, there have been two New Zealand studies that confirmed such variation in clinical care, using standardised patients presenting to general practitioners with asthma (O'Hagan et al, 1989) or migraine (O'Hagan et al, 1986).

The failure of implementation of clinical guidelines is another example. Such guidelines are based on evidence based medicine (with all the inherent positivist assumptions of RCTs etc), but doctors seem to have great difficulty in altering their behaviour in response to them (Basky, 1999; Little et al, 1996).

Yet another example is the concept of the "heart-sink" patient. O'Dowd (1988) initiated an interesting debate about these patients who had been previously labeled in derogatory
terms as “hateful” (Groves, 1981), or “medical care abuser” (Ries et al, 1981). In New Zealand the discussion on this is less well developed, but the term “difficult” has been used, as it is the perception of the consulting doctor that determines whether or not a patient is labelled as “difficult” (Wilson, 1995).

Butler and Evans (1999) located doctors’ difficulties with these patients in the doctor-patient relationship. Their definition of heart-sink was “a negative response from the clinician to the presentation of personal, social or spiritual suffering in ‘clinical terms.’” They concluded:

*The heartsink phenomenon seems to be a symptom of the tension within the philosophical foundations of general practice. They present general practice with a fundamental challenge... between just a biological focus (in which the soteriological dimensions of health are excluded), and a broader medical paradigm in which the personal, social and spiritual are legitimately included.*

(Butler and Evans, 1999, page 232).

In a constructivist paradigm, these difficult or heartsink patients would be less disadvantaged, as the practitioner would adhere less tightly to the idea of searching for a biological reason for the patient’s distress. The science of comprehension of these patients would be through understanding and researching the doctor-patient relationship, something that was initiated over 50 years ago by Balint, and which is only now gaining acceptability as a legitimate area of research. The patient’s narrative would also gain further emphasis (Hunter, 1991).

As already noted in the discussion on anomalies, there is already considerable interest in researching the communication between doctor and patient, with growing evidence that the interaction between patient and doctor has a significant effect on the outcome of the consultation (Bass et al, 1986; Brown and Freeling, 1976; Byrne and Long, 1976; Kaplan
et al, 1989; Kinnersley, Williams and Weinman, 1988; Neighbour, 1987; Spiro, 1993; Stewart 1995; Stewart et al, 1979). The evidence contradicts the positivist epistemological basis of biomedicine that the doctor can observe without influencing what is being observed, but such findings are readily understandable given different philosophical assumptions.

3.18 The ongoing crisis in medicine

Despite these contributions from various medical thinkers and researchers, the present medical community is still dominated by biomedicine. Medical journals continue to publish more quantitative than qualitative research, and more research funding goes to the former. Practitioners are still trained in orthodox biomedicine, but there is considerable tension in practice, where the clinical anomalies and various clinician behaviours could be indicative of a different model. Some physician behaviors are better understood by acknowledging the underlying paradigmatic tensions within everyday practice.

Other writers (not already listed) have also reviewed the philosophy of medical science (Denz-Penhey and Webb, 1992; Mathers and Rowland, 1997; Rainsberry, 1986). There have also been debates in other disciplines such as anthropology (Crary, 1995; Grinslow and Hart, 1995; Guba, 1990; Pasquinelli, 1996), in physics (Heisenberg, 1958; Sheldrake, 1990), in education (Heshusius and Ballard 1996), and politics (Janos, 1986). The central thread in these other fields has been the shift away from positivist and realist stances toward more subjectivist models, where cultural relativity and observer subjectivity became more acceptable. Heshusius and Ballard, for example list personal testimonies of several educators who have managed to change their professional paradigm.

In summary, the philosophies underlying the art and the science of medical practice are paradoxically dissimilar. Much of the criticism about modern practice could be attributed to an inappropriate application of a nomothetic science to the individual patient. The proposal listed here for a social constructivist medical model precedes the rest of this
thesis, so that the method of research and the data obtained are consistently located in a
coherent philosophy of research and practice. Similarly, the results of this thesis can be
interpreted within both the historical context of medicine and the emerging medical
models.

3.19 Theoretical foundations of general practice in New Zealand

The theoretical background for medical care in New Zealand is based on biomedicine.
The system is strongly derived from the British model with the same historical links
(Loudon, 1984). There is a partially subsidised fee for service in primary care with a
range of health professionals including GPs and various nurses. There is fully subsidised
secondary and tertiary back up in hospital institutions. There are two medical schools.
In line with medical education around the western world, there are moves toward
“problem based” medical education, with an increasing emphasis on communication
skills for undergraduates. Bio-psycho-social theory is taught explicitly, and as already
noted there are some moves toward introducing patient-centred medicine as the definitive
curriculum.

There are about 2500 GPs in New Zealand; most are locally trained and are members of
The Royal New Zealand College of General Practitioners (RNZCGP), a body now
responsible for ongoing accreditation of members. From my personal observation, I
estimate that between one and three per cent of GPs use supervision. Paradoxically, their
experiences and observations on the culture of practice in New Zealand are important, as
they clearly identify some of the problematic aspects of working life. Simple
generalizations from their experiences will not however be possible to the rest of the GP
community, but certain aspects will be transferable to other contexts. This issue is
reviewed in Chapter 11.

A recent feature of practice in New Zealand is that over 90% of GPs are members of peer
groups, where between four and ten GPs meet regularly to discuss their work (Watson,
1997). The generic origin of these groups would seem to be the Balint concept, but in NZ these groups are usually self-led. Groups with a consultant psychiatrist as leader would be closer to the original Balint idea, but these are very uncommon with less than ten in the whole country. Some of the GPs in this study have had considerable experience of peer groups; the structure and function of peer groups are compared with supervision in the results.

3.21 Personal observations of the epistemologies of New Zealand doctors
My role as lecturer at Otago University has given me a unique opportunity to observe students and mature doctors in their training and their work. This has allowed me to review their approaches to the patient at different stages in professional development. For example, second and third year students are explicitly taught about the patient’s illness experience alongside their studies in anatomy and biochemistry, but their focus from fourth to sixth year is increasingly on disease identification and disease management. As House Surgeons in hospital practice, the exigencies of their role as admitting doctors to secondary care means that most of the steps of a patient-centred approach are omitted. The very pragmatic basis of such a disease-orientated practice means that only Steps 1A (disease and differential diagnosis), 4D (ameliorating the effects of disease), and 6A and B (being realistic about time and resources) are included (see page 37).

When these doctors emerge from the tertiary environment and enter the general practice training programme, they face considerable epistemological difficulties. The patients they now see have undifferentiated problems, with only some of those able to be categorised as disease. Similarly, psychosocial issues intrude more on management than with the inpatient population of hospital practice. I was the leader in 1999 of a regular discussion group about “difficult” patients in general practice. From my perspective, the doctors’ difficulties with certain patients arose when they could not find any well-defined pathology and seemed reluctant to attribute the patients’ distress to inter-current personal
and social issues. For example, a young adult patient with back pain would be fully investigated with X-rays, referred for physiotherapy, given a range of medications including tricyclic antidepressants for chronic pain, and eventually referred to the specialist, all of which were unhelpful. In the meantime the patient’s story of being an unsupported solo mother under pressure from Social Welfare about her sickness benefit would slowly emerge. This discussion is not to deny the place of good clinical medicine; rather, as an older GP I seemed more comfortable with the idea that the patient’s narrative story was significant. In contrast the registrars tended to reify those details in diagnosable syndromes (chronic pain syndrome, depression and so on).

With the more mature general practitioners in the Masters programme, I have had further opportunity to review their underlying approach to clinical practice. Most seem more comfortable with “story”, and tend less to investigate out of fear of missing a diagnosis. However, even quite mature GPs seemed still to be struggling with the mind-body dualism that as McWhinney has stated “runs across medical practice like a fault line” (McWhinney, 1996). Despite acknowledging that psychosocial elements are important, these GPs still have considerable difficulty in convincing their patients of the same, and continued to feel doubtful that simple validation of patient’s stories could, in some contexts, be sufficient in itself as an adequate intervention.

The discussion above is evidence of how GPs in New Zealand are struggling to reconcile theory and practice. While they were given a theoretical model in medical school, they find anomalies in clinical practice that create considerable tension. One of the reasons that they spend little time however, on the resolution of those underlying philosophical paradoxes is the ongoing restructuring of medical practice every two or three years.

3.22 Organisational changes to the structure of general practice in New Zealand
In the last ten years the American concept of managed care has been increasingly influential. The health reforms of the last decade in New Zealand have been a version of
managed care, with the entire country now being seen as having limited funds. A government agency called Pharmac now purchases medicines from international drug companies with a brief to limit and control drug prescribing. There is also increasing managerial influence over the range and extent of operative interventions, numbers of patients seen at outpatient departments, and the range of allowable activities for various practitioners.

The 1980s also saw a community-led revision of medical ethics following a public outcry over unethical medical research at National Woman’s Hospital in the 1970s and 1980s. Without patient consent, Professors Bonham and Green had attempted to follow the natural history of untreated cancerous cells of the cervix. The greater attention to informed consent in New Zealand stemmed from this ongoing ethical debate. One important outcome was the creation of the Health and Disabilities Commission (HDC), which now functions as a de facto watchdog of medical practice. The Code of Health and Disability Consumers’ Rights includes the rights of the consumer and the duties of the health professional. The HDC receives and processes complaints against health professionals, referring more serious breaches of practice to the New Zealand Medical Council for disciplinary procedures. While these initiatives may have been helpful for patients in having their concerns addressed, the recent research by Cunningham (1999) on the effect of disciplinary complaints has confirmed how disabling the complaints and disciplinary process is for the doctor concerned. With the emphasis on the duties of the health professional (to the exclusion of rights), the Code would appear make these disciplinary processes even more difficult. The end result of cultural moves to reduce the paternalistic style of practice of the 1960s and 1970s could result in increased stress for individual practitioners, with theoretically negative (unintended) effects for patients. The GPs in this study have had some experiences of the HDC, and these will be outlined in results, in relation to the theoretical background above.
CHAPTER 3: The philosophy of medicine and the culture of general practice

3.23 Stress in general practice

In the United Kingdom in the 1980s there were similar managerial health reforms in the National Health Service. Practitioners faced considerable organisational change with evidence that the changes were stressful. This may have been because of increased accountability and decreased autonomy (as already noted in Chapter 2). In New Zealand the factors listed above (increased managerial influences and revision of ethical standards and accountability) are similar in purpose and design to the changes in the NHS, and it is likely that they are contributing to current GP stress in New Zealand.

These stresses been acknowledged by the RNZCGP, who launched the “Self-care Pack” at the annual conference in Queenstown in 1998 (Barker, 1998). This initiative listed a number of professional supports and activities for GPs, ranging from peer groups, to personal psychotherapy, to meditation, to supervision. However the individualistic style of practice in New Zealand prevents more widespread use of the Pack. Although many GPs work in group practice, many still feel isolated and unsupported (Barker, 1988). The “Lone Ranger” concept is apparently well established, although one positive outcome from the managerial reforms has been that practitioners are now forced to work together to overcome funding and health delivery issues. The advent of collective after-hours centers to cover evening and weekend work in the last decade has also meant many GPs now meet more regularly with their colleagues.

In 1999, the RNZCGP annual conference held a forum on “The low morale in general practice”, so the issue of stress in general practice appears to be ongoing. The recent study in Wellington by Dowell et al (1999) would appear to show that GPs are under appreciable stress from the ongoing re-organisation of medical practice here in New Zealand.

One of the other stresses in practice is a perceived lack of competence with patients who present with psychiatric disorders. A Dunedin survey currently in progress (Egan, personal communication, 1999) is using a comprehensive questionnaire, showing that
while GPs are comfortable in diagnosing such disorders, they continue to feel uncomfortable about their own management skills. A high percentage wants further education on how to treat those patients, even though a quarter of the respondents had already had some psychiatric training.

3.24 Knowledge of supervision in general practice in New Zealand

Chapter 2 listed some of the responses to stress in the helping professions, with one option listed being that of supervision. As an example of the degree of awareness of these issues in general practice, a group of GPs attended an educational session in 1999 on methods of professional maintenance. The discussion here grounds this research into the practical and immediate issues facing GPs in New Zealand, while further illustrating the conceptual themes in this thesis.

The resource person for the session was an experienced supervisor with a brief to lead discussion and exploration on mentoring. So far in this thesis, I have avoided the term “mentoring” for two reasons. Firstly, the theoretical background for this research has been from the supervision literature (where mentoring as a term is not so prevalent), and secondly, supervision is the term the respondents all use. However, just as Freeman (1998) discovered in the UK, mentoring seems to have less judgmental, critical, or directive connotations than supervision. From my perspective, the description of mentoring from the resource person was exactly that of GP supervision, and so the subsequent discussion at the time was directly relevant to this thesis, albeit given a more acceptable title for the participants. The list of learning needs about mentoring was mostly concerned with how to define mentoring.
CHAPTER 3: The philosophy of medicine and the culture of general practice

Table 3.3 Learning needs at the educational session

- Define mentoring.
- Define roles of the mentor and mentee.
- When and how to become a mentor, does it change in different circumstances?
- Transition between roles/boundary issues.
- Styles and schools of mentoring.
- Preserving the "meaning" of the mentoring activity.
- Choosing a mentor - how to terminate the relationship.
- Cultural shift and mentoring within organisations/institutions.
- Can one learn if you don't like or respect the mentor?
- Is a one-to-one relationship necessary?
- Does the mentor need to be mentored and if so, how?
- Evaluation and outcomes; is it worthwhile doing?

Some important issues were clarified at the time leading to some understanding of what GP supervision or mentoring is. (The answers to all of these questions are found at various points in this thesis). However, the questions illustrated the relative scarcity of the mentor-mentee relationships in medical culture, and the lack of understanding of the concept of mentoring or supervision in general. Similarly, as part of my teaching portfolio in the Dunedin School of Medicine, I contribute to a course on mentoring for undergraduate students. The first year of this course has been marked by some resistance to the idea of mentoring, with students being uncertain what to expect from their mentors. The doctors who were chosen to be mentors similarly had substantial difficulty in defining their role. In both of these educational activities, it became apparent that the mentoring relationship was a relatively new experience for most of those present.

The culture of general practice in New Zealand then, has both historical and local influences. There are epistemological and organisational stresses on GPs, with few of them having well defined professional maintenance activities apart from their peer groups, while the concept of mentoring or supervision is poorly understood. How the GPs in this study have "discovered" supervision is a major aspect of this thesis.
3.25 Summary

Biomedicine has dominated western medical science in the twentieth century and the underlying philosophical basis to this has been postulated in some detail. Some of the criticism for biomedicine could be explained by the idea that medicine is currently in a paradigm crisis, using the Kuhnian model of scientific revolutions. Certainly, there are a number of significant anomalies in current practice, which call for a revision of the medical model. As in any scientific paradigm, practitioners adhere strongly to their preferred beliefs and take their underlying assumptions for granted. At present some medical schools are engaged in reform of their curricula, which will entail (unacknowledged) paradigmatic discussion.

The concept of paradigm is an important one, as today's practitioners are working in the confusion of shifting philosophical grounds, where emerging alternative models are challenging the dominant paradigm. Kuhn's thesis indicated that practitioners in such an era find it conceptually difficult to feel secure in their practice. Either they ignore the anomalies of practice, or else they need to review their underlying assumptions and philosophical allegiance. Both options in fact present considerable strain on professional life. How the GPs in this thesis use supervision, given this particular context of paradigmatic uncertainty, will be outlined in considerable detail in the chapters of results.

Next however, is an outline of the method of research for this thesis. This is presented in detail, given the historical emphasis in traditional medicine on randomised-controlled trials and other objectivist research. Qualitative research is located in an entirely different paradigm, with specific assumptions and considerations quite foreign to most medical practitioners. These details will be presented in Chapter 4.
CHAPTER 4: Method

4.1 Introduction
Traditional methods of research such as randomised controlled trials would be unsuitable for this thesis, in which the experiences, observations, and individual philosophies of a group of practitioners are the subject of enquiry. Objectivism and positivism have dominated modern medicine, and so the emerging paradigm of qualitative research is still in the process of becoming acceptable. Because of these reasons, this chapter explicitly outlines all the steps in the research process. This is followed by a review of the issue of reliability of data analysis. This review includes an audit trail of the research activities, so that an independent reviewer could verify each step that led toward the emergence of the themes and the topics within those themes. Secondly, several “validation points” are listed that indicate how the respondents in this research contributed to, and confirmed, the interpretations of the data. Thirdly, the interventions from the research supervisor are listed. These acted as points of quality control in the research process.

The steps of the research process for this thesis are summarised in Table 4.1, and then these will be discussed in turn.

Table 4.1 Summary of methodology
- A theoretical framework was developed for qualitative research.
- Background issues in supervision were reviewed.
- Ethical consent was obtained.
- Seven GPs were interviewed using an unstructured interview schedule.
- The interviews were transcribed.
- The data was sorted into various units of meaning for each interview.
- Using specific steps, the units were integrated into thematic diagrams.
- A focus group was used for feedback on the interim findings, and that data transcribed and sorted.
- The thematic diagrams were then further developed.
- The research was written up.
4.2 Theoretical framework
This research was consistent with the social constructivist paradigm presented in Chapter 2. This paradigm is different to that of biomedicine, which has its strengths in clarification of disease, in measurement, prediction, physical parameters, and objectivity. Yet one weakness is in phenomenology; the experience of patients, their narratives, personal ethics, or subjectivity. A further weakness in biomedicine is the relative absence of accounts about doctors' personal experiences of their work. The contribution from Balint on the doctor's experience of their "difficult" patients is perhaps an outstanding exception to this criticism (Balint, 1956). Another exception is the emerging genre of pathographies, which are personal accounts by doctors of their own experience of illness (Ingelfinger, 1980; Rabin, 1982). In general, research on the experience of being a doctor (phenomenological research) is uncommon in medicine.

Researching supervision then, is located in an emerging genre that includes the doctors' contribution to, and their experience of, the process of medical care. Such a study can yield significant insights into issues such as professional development, the doctor-patient relationship, learning through reflection, and differences and similarities between general practice and counselling, where more traditional methods of enquiry would be ineffective. The theoretical framework for this research was qualitative or ethnographic, and the method chosen was unstructured in-depth interviews.

4.3 Ethical considerations
There was no need for patient consent as patients were not involved, except through doctors' stories about their patients, in which identifying details were omitted. Written approval was received from both the Otago and Canterbury Ethics Committees. The proposal letters and the consent forms to prospective subjects are in Appendix 1. Confidentiality was achieved by limiting the readers of the transcripts to the transcription secretary, the research supervisor, and myself. Identifying data were removed before quotes were used, and pseudonyms are used in the five chapters of results. The teleconference focus group was interesting ethically as some of the doctors knew each other already and had been quite open with each other about my research. Despite this openness, it was important to minimise speaker identity. First
names only were used in the teleconference, attendance was by separate signed consent, and pseudonyms were used in the transcription.

4.4 Interviews as choice of method
Interviews were chosen to discuss the experience of supervision, rather than using direct observational studies. For example, participants could have shown videotapes of supervision sessions, or I could have requested permission to directly observe the supervision process. I chose not to do either of these for several reasons. Firstly, I have had personal experience of a number of styles of supervision, and am knowledgeable about its structure. Secondly, in anthropology, sociology and education for example, the method of data collection by interviews is already well developed. Thirdly, the process of the research method needed to be congruent with the process of supervision (which in turn is congruent with the process of consulting). If patients can resolve their issues by “just talking” with their doctor, and if doctors can resolve their issues by just talking with their supervisor, then it should be possible for a researcher to understand the supervisory process by just talking with the doctors involved (Figure 4.1).

Figure 4.1 Parallels in various interactions

<table>
<thead>
<tr>
<th>talks with</th>
<th>patient</th>
<th>doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>doctor</td>
<td>↔</td>
<td>supervisor</td>
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<tr>
<td>doctor</td>
<td>↔</td>
<td>researcher</td>
</tr>
</tbody>
</table>

A different possible method would have been to interview the supervisors to confirm the findings (with the GPs’ consent), but that could have caused the doctors to become self-conscious, knowing their supervisor would be discussing their details later. Further, the supervisors could comment only vicariously on the other’s experience. In addition, such a combined study would be beyond the scope of this
degree, although it would be extraordinarily fascinating. (See for example, Doehrman, 1976.) Written questionnaires as a research tool for experience-orientated research were similarly considered but rejected, as set questions would only produce answers to those questions. Even leaving space for spontaneous comments would not resolve this, as there would be no immediate forum for interactive clarification or discussion of the issues raised spontaneously.

4.5 Sample selection

The “snowball” method of building up a sample was used (Maykut and Morehouse, 1994). Initial interviews were with GPs I knew personally, which led to other GPs who were also known to use supervision. Between June 1998 and May 1999, seven interviews were conducted in Otago and Canterbury with one interview in Wellington. These GPs could be called key informants, as they have led the development of supervision in general practice in the last twenty years. The interviews were all performed in participant’s homes in the weekends, so there would be less time pressure and participants would use a more reflective voice. As the interviewer in this research, I tried to combine respect for their stories of their supervisory experience with specific questioning on certain points, and even gentle confrontation at times to clarify inconsistencies or confusion. There will be further discussion about issues in the interviewer-interviewee relationship in Chapter 10 (Validity and Transferability).

4.6 Transcription

I employed a transcription secretary to transcribe the taped interviews into the computer. The initial instructions to the transcriber were as follows (see Table 4.2)

Table 4.2 Initial instructions for transcription

- Type in every word, including repetitious phrases
- Separate lines for the interviewer and interviewee, although short comments could be included in other’s text
- Researcher in bold.
- Note pauses, laughter or other non-verbal interactions.
CHAPTER 4: Method

However, Elwyn and Gwyn (1999) noted the superficiality of current studies on the doctor/patient interaction, and urged clinicians to use discourse analysis to listen more constructively. They recommended more detailed transcription instructions to improve the validity and reliability of discourse analysis. These include underlining the emphasized word of a phrase, calculating the length of the pauses in seconds, and including every utterance down to the last “um”, or “ah”. I experimented with one short section of an interview, and found that this method did indeed facilitate text analysis. Here is the original text from the secretary:

*Interviewer: So what are the barriers to general practitioners to take on supervision as a mode of self-maintenance?*
*Interviewee: Finding a supervisor would be one of the big steps. Understanding the need. See, the barrier that I suspect, is that not understanding what the benefits that come from it are. ‘Cause you have to put a lot of work into supervision. I mean, in my case, there’s the travelling, and finding that bit of the month that I can actually take an afternoon off, and pay for it. And, either it eats into my work time, or it eats into my leisure time, so you have to value something quite a lot to do that. So, I think the main barrier...*

Elwyn and Gwyn’s key was as follows:

**Table 4.3 Key to more detailed transcription instructions**

- (. ) Pause of less than 2 seconds
- (3) Pause of 3 seconds
- Underlined word; where emphasis made by the speaker
- Interviewer in bold
- Transcribe all words including umms, and ahs etc

Using these instructions with the same interview gave the following transcription (next page).
Interviewer: So what are the barriers to ah, general practitioners to take on supervision as a (...) as a mode of self-maintenance?
Interviewee: Mmm, Mmm. Finding a supervisor [mmm] would be one of the big, um big steps. (...) Um (...) Understanding the need. [mmm] See, the barrier [mmm] that I suspect, is that not understanding what the benefits that come from it (...) are. And (...) 'Cause you have to put a bit of work into supervision. I mean, in my case, um there's the travelling [mmm] and finding that bit of the month that I can actually take an afternoon off, [mmm] um, and pay for it. [mmm] And, either it eats into my work time, or it eats into my leisure time [mmm] so you have to value something quite a lot to do that. So (3) I think the main barrier...

The purpose of this extra effort was to facilitate the gleaning of meanings. Whether it would have yielded a different overall thesis if all the interviews had been done in this way is debatable, though it seemed to give a more accurate feel for the subtle nuances of oral speech, which were usually lost in the down-loading from tape to text. From this experience, I altered the method of transcription in the later interviews to include the underlining. What also emerged from doing this exercise was how involved the interviewer was with the subject.

However, there are limitations in any method of transcription. The simple phrase “the interviews were transcribed” also does little justice to the conceptual difficulties of transferring oral speech to a written text. Interviews take place at a certain time and in certain surroundings, and both the interviewer and the interviewee “bring considerable conscious and unconscious baggage into this moment” (Scheurich, 1995). All of this may be lost when one reads the manuscript, as the transcript is an artificial construction from an oral to a written mode of communication. Kvale (1996) noted the hegemony of transcripts in interview research, but their dominance is perhaps not surprising, given the emphasis this century on an “analytic, abstract, and objectively distanced forms of thought and expression” (p 167). According to Kvale, an oral cultural tradition (“situational, empathetic, participatory”) would put less emphasis on abstract conceptualisation of human encounters in order to learn their inherent “truth.” The tendency in modern science however, has been towards reductionist methods of understanding. Despite these conceptual limitations, I found that transcriptions were a useful tool for the analysis of interview data, being the bridge between a complex human interaction and the later distillation of themes and issues, and I had no intention of inventing a different method.
4.7 Thematic analysis

After the first interview was transcribed, the Windows Tool Bar on Word '97 was used to copy and paste various quotes from the transcript into a new document called Themes. Headings included for example, “Differences between Peer Groups and Supervision”, “Effect on Career Development”. I then did several more interviews, but struggled to reconcile the new data with the existing themes. These difficulties were resolved by following the procedures suggested by Maykut and Morehouse (1994; pages 127-149), who recommended a physical cut-and-paste method. With some adaptations this method was eventually adopted, and the data analysis was started afresh. The four steps to the data analysis were: **Unitizing, Sorting, Comprehending** and **Writing up**. The first three are summarised in Tables 4.4 to 4.6 (Adapted from Maykut and Morehouse, 1994, pp 127-149).

**Table 4.4 Unitizing**

1. Each transcription was completely rechecked.
2. Pages were numbered and labelled with the initial of interviewee (for example, R.)
3. Lines were drawn between the units of data. Each unit of data had to be understandable by itself, and all data had to be unitized. These could include questions from the interviewer.
4. Coding: each unit of data was labelled with its meaning in the margin; for example, “purpose of supervision”, or “difference between supervision and Balint group.” The page number was included (for example, R4 indicated Robyn’s interview page 4).
5. Each completely coded transcription was then photocopied.
6. Individual units were then cut out; the original coded interview was ticked off and kept for later review.
7. Each unit was sellotaped to a separate card, and labelled at top with meaning and page number.
8. For each unit a highlighter was used to show why that unit was labelled with that meaning; those highlights formed the basis of the quotes used in the results.
9. A flow diagram was then developed for each subject's experience of supervision, by reviewing all units from that transcription.
CHAPTER 4: Method

The individual flow diagrams were helpful in keeping a more objective overview of that particular narrative. For example, see Figure 5.1 on page 70, which was the flow diagram for Robyn.

The next step was to integrate all the individual diagrams into general diagrams, as well as putting all the individual units into folders of the same meaning or category (Table 4.5; sorting).

Table 4.5 Sorting

1. An initial general theme and issues diagram was developed from several of the subjects' flow diagrams. This included all the categories of meaning and the relationships between the categories.
2. Folders were labelled with the names of the categories
3. Each unit was placed in its appropriate folder
4. The units were resorted; inevitably some units changed categories, as the process became more sophisticated.

The third step was to create an “inclusion rule”, as part of a deepening comprehension of the units and their meanings in each folder (Table 4.6).

Table 4.6 Comprehending

1. Each folder then had several units of data from different respondents. The reason why those units were included was then written. This was the inclusion rule for that folder.
2. Several folders were then grouped together under more general principles. A second general themes diagram was then written using these general principles. The units of meaning were now embedded into broader generalisations, and the underlying principles were starting to emerge, for example, exploration, reflective practice. Figures 5.8 and 5.9 on pages 76 and 77 show how the general themes diagrams evolved as more and more data was entered from the later interviews.
These three steps were rigorous, and each transcription took many hours of work before I felt satisfied with its eventual analysis. My own preference was to use this physical cut-and-paste method. Other researchers have found programmes such as "Nu-dist" helpful, but my initial experience of unitizing by computer was quite disappointing, and forming inclusion rules seemed to be easier on paper than on screen.

4.8 Writing up

Parts of this thesis were written during the research process, rather than after finishing the final analysis. Writing the results took several months, as each major theme required a further critical re-evaluation of previous literature on that topic within the medical context. Each chapter required several drafts and considerable re-editing before passing it on to the research supervisor for her final comments.

The background to writing this thesis was the prior work in the first part of this Masters degree, where by way of the assignments, I developed ideas on reflective practice (Wilson, 1995), “difficult” patients (Wilson 1996), and paradigms in medical research (Wilson, 1999b). Completing those assignments was critically important in my approach to this thesis. In a similar way, it was in the writing-up of text that my initial vague notions of reality were transformed into more coherent ideas.

Knowledge for me is not a “natural history description” of rocks and leaves; rather, it is a socially constructed process. I was not searching for the ultimate or universal truth because this thesis is only one of many possible interpretations of doctors’ experience of supervision. The writing process outlined here was an integral part of knowledge construction.

During 1999, two courses were of particular help. I attended at a two-day intensive workshop on supervision in Dunedin with Tony Williams in May, which helped the theoretical background of supervision in Chapter 2. Secondly, I attended a year-long university course on qualitative research, which was pertinent to the research philosophy and to the method of data analysis presented here.
What follows now is a discussion of the validity of this particular research process. This includes an audit trail, back-up from the research supervisor, and some points of validation from the respondents. As Kvale has pointed out, validity is integrated into the "craftsmanship" of the work (Kvale, 1996), as well being integrated within the underlying philosophical stance of the researcher.

4.9 The audit trail
The procedures of data collection and analysis have been described in sufficient detail so that an independent researcher could review each step in this thesis. Such a review could confirm that the interpretations of the data (presented in the next few chapters) were in fact reliable interpretations, and that the process is to some extent, reproducible. The audit trail is presented schematically in Figure 4.2 (next page).

There were eight transcriptions, each between seven and thirteen thousand words. The interviews could thus be reviewed for the accuracy of transcription (Audit point 1). These eight transcriptions were itemized, yielding between 30 and 45 items each, and the original itemization notes on each transcription are also available (Audit point 2). Items were then place into twenty-six folders of a similar topic (for example, Needs, Barriers, the Supervisor-doctor relationship and so on). Each folder had between three and twenty-five items (Audit point 3). After considerable review of the items in each folder, an "inclusion rule" was developed which stated why each item was actually in that folder and not in another (Maykut and Morehouse, 1994). This rule became the basis to each section in the results chapters. An independent audit of this research could review those inclusion rules (Audit point 4).

The folders were then grouped into major themes, and I have outlined how these evolved and changed in section 4.7 above. The research supervisor reviewed the final arrangement of folders into themes, and this step was also a series of decisions that could be reviewed (Audit point 5). When writing up the results, relevant quotes were chosen from each folder of units to illustrate the inclusion rule. This was done on computer and chosen quotes were placed in Italics. In this way a later reviewer could see if the quotes were an accurate representation of the whole folder (Audit point 6). Similarly, if there were any "deviant" findings that did not support the main ideas of this thesis and were not used, they could be identified and discussed (see Figure 4.2).
Figure 4.2 Audit trail of research activities

Audit points
1. Audiotape to transcription
2. Unitization of transcriptions
3. Sorting into folders
4. Formation of inclusion rule for each folder
5. Organisation of folders into themes
6. Selection of quotes for the results chapters

Choice of quotes for the results chapters
CHAPTER 4: Method

This audit trail was designed to make the process of this research as transparent as possible. There was an observable line of continuity from the observational data (the actual words in each interview) through the transcriptions, the units, the folders of topics, the quotes used in results, and finally to the inclusion rules that initiate each section in results.

4.10 Validation from the participants

The participants in this study were involved in the research process at several points. These will be listed as “Validation points” from 1-4. At their interview, participants had many opportunities to state their experience. The interview style was one in which points were clarified at the time. By going over and over points, it seems likely that going over and over points largely eliminated uncertainties and ambiguities. This process was designed to increase the face-validity of the observational data (Validation point 1).

All participants were sent their transcriptions and four of them returned those with extra notes that were incorporated into the findings. None of those notes were to deny or recant any previous statements (Validation point 2). In terms of getting validation from participants in this way, this figure of over 50% was quite high; Varian (1998) and Carryer (1997) for example, received very little feedback on the written transcriptions.

Did the interim findings of this research “ring true” for the participants? Validation point 3 was at the focus Group. The letter of invitation to the focus group (see Appendix 2) also included several questions arising from a first review of the transcriptions, and these were intended to take the discussion into a deeper understanding of the underlying themes. The questions for the focus group were as follows (Table 4.7).
Table 4.7 Focus group questions

1. Is “supervision as part of a reflective practice” a fair summary of your use of supervision?
2. What are the specific features of the supervisor-doctor relationship that make it so powerful?
3. What are the features of the current culture of medical training and practice that make the concept of supervision so foreign to most doctors?
4. Has supervision resolved the “dissonance” between your beliefs about how your practice should be, and the reality of practice before you started supervision?
5. What are the features of the doctor-patient relationship that facilitate healing in the patient?
6. What are the barriers for you to become mentors for other GPs?
7. Should supervisors be psychotherapists rather than doctors?
8. Why is it difficult for the doctor-as-patient to experience healing (in the doctor-patient relationship?)

The first seven of these questions were directly related to what appeared to be the emerging topics and themes in GP supervision. The last question was related to the doctor-patient relationship as experienced by these practitioners (in the role of patient). At the focus group the discussion was quite animated with much of its transcription being used eventually as quotes in the results. This implies that the participants were fully engaged with the topics and that the discussion was directly related to the themes at hand.

The participants were asked to review two of the early thematic diagrams and comment directly on the initial analysis. The following quotes are included here to illustrate this process of validation. The diagrams referred to are on pages 76 and 77, and pseudonyms are used in place of the real names of the respondents.

Okay, well look, what I first wanted from you all was really some feedback on those rather complicated diagrams that I sent out, just to see if you think that I’m in the right ballpark with all that. And they were diagrams that were kind of distilled from all the interviews. I kind of collated them all together into those rather generic or generalisations diagrams. So has anybody got any comments on those for a kick off?
Robyn: Oh, look, I found that Version A/General themes seemed quite a good summary of the process. And I got a bit lost in Version B.
Yeah, fair enough. Version A was pretty much straight as it was, for a lot of people who I’d interviewed. Version B was kind of trying to change that into broader sort of categories. Is that a bit too vague is it?
Robyn: Oh, well, the amount of time that I spent on it which wasn’t great, it was not very clear for me.

Fair enough, thank you, I need that. That’s good... How about you, Paul?

Paul: Yeah, I warm to the expression of dissonance. Cause I think that’s what drives all this actually, and continues to drive it and the fact that you’re always finding that what somebody says should happen and then you find that it’s not quite like that and so you’re actually asking yourself why or how or whatever...

“Warming to the expression of dissonance” seemed to “warm up” the teleconference, as the participants then had an in-depth discussion on the appropriateness (or otherwise) of having to use a “Read Code” (to codify each consultation. Eventually the discussion was lead back to the concept of dissonance.

Okay, so going back to dissonance.... Would that word ring okay for you would it?

Paul: Oh definitely.

Right, and one way of resolving that dissonance is to reflect on it.

Paul: Yes, reflect and you know, talk about it, and that’s where I find that supervision is a place where you can throw that around without... Cause sometimes it’s quite threatening to your colleagues if you actually, you know, say the whole things crazy, it’s not going to work, or that it’s... I mean you need a forum where you can... a place where you can actually say these things and actually get someone to throw it back at you and reflect on it, you know what I mean?

Dissonance then, as a theme, appeared to have been validated by these participants, and so this was retained in the overall schema. On the other hand, another of the themes in Diagram B, “reflective interpersonal practice”, was discussed below. The statements in bold here reflect an attachment by the interviewer to this concept which was not so well validated by the group.

So, with that first question again. Is supervision as a part of a reflective practice? Well, that would be a fair summary for some of you then wouldn’t it? I don’t want to put words into your mouth but having a reflective practice on your work is clearly an integral part of some of your way of thinking about your work, is that fair enough to say?

Mark: That’s one aspect isn’t it.

Others: Yeah, mm.

Mark: I mean as it stands, it’s a summary of our use.

Yeah, so it’s only one aspect....

With summary we need to... or is it a facet or...

Yeah, a fair facet would be a better word.
On review of this, it seemed that reflection was only a "facet" of their use of supervision and so the thematic diagram needed further review. Following discussion with the research supervisor, the final thematic categories were eventually reformed. These were outlined as Version C, being the basis of the results.

This process of review from the participants (transcriptions, themes, feedback and then review of themes again) is described in almost all the literature on qualitative research (Maykut and Morehouse, 1994), although specific examples of the details of doing so are less commonly reported. In a similar way, the idea of triangulation of data from a variety of sources is also noted as a way of improving face-validity (Mays and Pope, 1998). In this research, my choice was to not ask opinions of others; for example, from the supervisors or from patients of these GPs. I have already outlined the reasons for this decision on page 54, and further, given the consistency and apparent authenticity of the material, confirmation by third parties seemed unnecessary. Another measure of the authenticity of this research is the extensive analysis of the data in the results chapters.

The participants also gave unsolicited feedback on the idea and concept of the research project as follows:

Mark: Good work. Yeah, it's a wonderful project. And I've really got a... It's been wonderful hearing you other guys tonight, and that idea which never really occurred to me that were different. (laughter from all).
Robyn: Really?
Mark: Well I was trying to deny it. Maybe I'm going to have to do a bit of accepting there.
Paul: Yeah (laughter)
Mark: You think about how... I mean I know it's your mission Hamish, but I mean I think that it's a really important mission to promote the concept of supervision. I mean in the patch of doctors that I work in, I mean they could all desperately do with about ten years worth (laughter). And they're not going to go out and get any.

This appears to be Validation point 4; that after completing an interview each and having joined the focus group, these participants were enthusiastic about this research and could see the wider perspectives that arising from it. I found this to be personally validating.
CHAPTER 4: Method

4.11 Back-up from the research supervisor
The role of the research supervisor in this research was to consistently interrogate the work in progress by attending to the underlying philosophical assumptions, giving specific help and advice where required, and by reviewing the initial drafts of each chapter. In this thesis, the supervisor started by interviewing me about my own ideas and thoughts on supervision. This allowed me to review my own prior stance on supervision, as well as modelling a way of interviewing (respectful, yet probing), which could be emulated in the actual research. Other input included:
• reviewing the initial ethics applications;
• advising on the number of interviews and methods of transcription;
• reviewing each transcript, and on one occasion offering some interpretive opinions about the flow of the interview;
• providing feedback on the diagrams;
• discussing the decision to have the focus group; advising on the further ethics application and producing resource material about focus group facilitation;
• reviewing the organisation of folders into themes;
• advising on drafts of each chapter.

In this way, a senior researcher with experience of qualitative research informed the work-in-progress, and the attention to detail contributed to the overall quality of the research process.

4.12 Summary
Because qualitative research has yet to be fully accepted into mainstream medical discourse, the details of the method used in this thesis have been presented at length. These have been mostly details of data analysis, and the validation points (especially point 3) from the participants go some way to reassuring the reader that the interpretations of the data were justified.

What follows now are five chapters of results. The first of these is an introduction, which sets the scene for the following chapters. These chapters will include specific quotes from the respondents with detailed analysis and discussion in each chapter. After those results, there is further discussion in Chapter 10 about the validity of
CHAPTER 4: Method

interviews as a research method and the possibilities (or otherwise) of "generalising" from this research to other contexts. It is only after that discussion that the implications of this thesis can be postulated in chapter 11.
CHAPTER 5: Introduction to results

This chapter gives a brief outline of each participant's story, using flow diagrams to highlight the pertinent topics. During the data analysis, these individual diagrams were merged into a series of general flow diagrams, which illustrates how the underlying themes emerged from the data. This process is outlined in some detail, allowing the reader to engage with the content of this research and to follow the reasoning that led to the final division of themes. This division is presented as a map of the findings, being a key to the topics in the following four chapters.

5.1 The participants
I interviewed seven respondents, and four of these were present for the focus group by audio-conference. The data analysis was then derived from eight transcriptions (seven interviews, one focus group) of between seven and thirteen thousand words each. The total data pool for analysis was over 90,000 words. All participants were active general practitioners in current practice in New Zealand, six with medical degrees from this country, with one graduate from England. Most worked in main centres. One GP was currently in rural practice, while two others had extensive rural practice experience. Two of the seven were in salaried positions in general practice. Three female GPs and four males contributed to the analysed data. All were in group practice, with ages from the mid 30s to the early 50s. All had had supervision for more than 3 years (up to 20 years). One of the GPs was not in supervision at the time of the study. The supervisors to the GPs in this study were mostly professional psychotherapists from a variety of theoretical backgrounds, with only one supervisor with a medical degree. Some of these GPs were aware of each other’s use of supervision and whom they were currently seeing. Two GPs had been to the same supervisor.

Each respondent is now listed separately, identifying the relevant details of their experiences of supervision. This is then followed by a flow diagram of needs, process and outcomes for each general practitioner. The details listed (for example, “open government”, or “modelling of process”), will be explained in further depth at various points throughout the results. A first name pseudonym is used for all the participants.
(Lee, John, Mark, Robyn, Paul, David and Wendy) and any identifying data has been either omitted or altered to retain anonymity.

5.2 Robyn

Robyn's primary use of supervision was to learn how to do psychotherapy. At the time of the interview she was meeting with her supervisor for two hours every month to review not only her clinical cases, but also to discuss more global aspects of her practice and professional development. In her interview, she addressed many issues, such as the barriers to getting supervision, how the supervisor modelled a certain process, and how supervision was different to other forms of professional support. Barriers referred to the issues and cultural factors that had to be worked through before she could use supervision. She used a separate room for her counselling cases, where she had one-hour appointments. She was particularly articulate about the boundaries between doctor and patient, the idea of letting go of the “Fix-it” role, and the difficulties of treating other doctors (Figure 5.1).

Figure 5.1 Robyn’s concept map

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerability</td>
<td>Separate room for counselling</td>
</tr>
<tr>
<td>Hospital culture</td>
<td>Shifts patient from physical to a more</td>
</tr>
<tr>
<td>Foreign concept</td>
<td>psychological focus</td>
</tr>
<tr>
<td>Time/travel</td>
<td>Lets go of “Fix-it” role</td>
</tr>
<tr>
<td></td>
<td>Aware of boundary issues with patients</td>
</tr>
<tr>
<td></td>
<td>Respect for patients</td>
</tr>
<tr>
<td></td>
<td>Being a doctor for other doctors</td>
</tr>
<tr>
<td></td>
<td>Doctor as educator</td>
</tr>
<tr>
<td></td>
<td>“Open government”</td>
</tr>
<tr>
<td></td>
<td>Career directions</td>
</tr>
</tbody>
</table>

Need
To learn psychotherapy

Supervision
For training and back up
Modelling of process
Sounding board
Is different to peer group
Taped cases for review
Two-chair work

Figure 5.1 Robyn’s concept map

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Outcomes</th>
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<tr>
<td></td>
<td>“Open government”</td>
</tr>
<tr>
<td></td>
<td>Career directions</td>
</tr>
</tbody>
</table>

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5.3 David

David’s journey into supervision started by attending some training groups on the somatising patient. From this he realised that he needed more back up for those patients, and joined a small supervision group. After two years he changed this to a one-to-one supervision arrangement, and at the time of the interview was with his second individual supervisor. His concept map illustrated a progression from needs to outcomes. He was explicit about his philosophy of practice and the importance of the doctor-patient relationship.

Figure 5.2 David’s concept map

Barriers
Vulnerability in group supervision
New concept

Needs
Wants to do formal counselling
Interested in emotional factors in patients

Supervision
Regular discussion about counselling cases
A place to go when feeling insecure
Dedicated reflective time
Defines the role of supervision (is not psychotherapy, is different to a peer group)

Outcomes
Increases self awareness
Feels more confident with ordinary general practice
Able to articulate a clear philosophy of practice
Explores additional methods of professional development
Emphasises the importance of the relationship between doctor and patient

5.4 Lee

Lee had explored several different forms of professional development, and her use of supervision stemmed from her interest in emotional factors in patients and the desire to do more formal counselling. She articulated the shame she had felt in previous medical group activities and was able to clearly define how supervision was different
to other group and individual work. The outcomes of supervision for her seemed to be in feeling supported in her role development as counsellor, and an increased confidence with ordinary general practice patients. Her phrase of “looking for the real thing” illustrated her concern to work at a deeper level with her patients.

**Figure 5.3 Lee’s concept map**

**Needs**
- Formal counselling
- Interested in emotional factors in patients

**Supervision**
- Discusses patient
- Role development as group leader

**Barriers**
- Shame
- New concept

**Outcomes**
- Feels sense of relief
- More confident with normal patients
- Clarity in interpersonal relationships
- “Sits with” the distressed patient
- Looks for the “real thing”
- Role of healer
- Shifts patients from physical to psychological focus

Regularly changes supervisor depending on current need

---

**5.5 Wendy**

In a similar way, Wendy had interests in counselling and an awareness of emotional factors. She used group supervision (two GPs meet with the supervisor every fortnight), and at times she stopped the supervision in favour of having personal psychotherapy. From both of these activities she had developed group leadership skills, knowledge of important boundary issues and of the role definition of the general practitioner. Rather than having separate counselling slots, she incorporated micro-counselling within her 15-minute appointments. Barriers are not listed in her concept map, as these were less of a feature in the interview.
CHAPTER 5: Introduction to results

5.6 Mark
Mark had originally used the former “Triple S” to subsidise the fees for his counselling patients, but more recently had used an IPA support scheme. He also booked patients for an hour and he differentiated between counselling and psychotherapy, seeing the former as an integral part of normal general practice. He had had extensive experience of different models of supervision and was currently using a GP with psychotherapy training as his supervisor. He brought a well-developed analytical mind to the theory and practice of supervision and was acutely conscious of the parallel processes between his relationships with patients and with the supervisor.

Figure 5.5 Mark’s concept map

Needs
Identified patients as having psychotherapeutic needs

Supervision
Several different supervisors over time, also experience of other forms of professional support

Outcomes
Hour long sessions
Uses self-disclosure
Aware of parallel processes
Juggles physical and psychological presentations from patients
5.7 Paul
Paul’s first experiences of supervision were in an informal group setting; he subsequently had one-to-one supervision with the same supervisor for almost ten years. He had developed a micro-counselling approach to the 15-minute consultation, and articulated how the supervisory process prevented his work being trivialised. He was available for “whatever they bring” and described the ongoing tension between the need for subjectivity and empathy, as well as for judicious detachment and objectivity. In his managerial role, he experienced significant resistance to the concept of supervision from his employers.

Figure 5.6 Paul’s concept map

5.8 John
John’s practice population had significant cultural and socio-economic needs and he had been in supervision for three years. In supervision, he reviewed not only the more difficult situations with his patients, but also many other aspects of professional life and professional relationships. In his interview, he saw supervision as a safety net, where he could identify and deal with ongoing issues of practice before they became too overwhelming.
5.9 The researcher

I am including some details about myself as researcher, as these situate myself as an insider with respect to the idea of supervision. I am a New Zealand medical graduate with twenty years of experience in hospital and general practice. I now work mostly in medical education and do part time general practice. I have had supervision myself for eight years, starting in a small group that wanted to explore approaches to the “difficult” patient. I have explored a number of styles of group supervision, some being multi-disciplinary with other professions. At present I am with my second individual supervisor. Being an insider to supervision means that I was able to readily gain the confidence of these respondents, without requiring elaborate explanations about the nature of supervision. How these background factors influence this study is discussed in detail in the section on Bias in Chapter 10 on validity.

5.10 General themes

From the individual diagrams I was able to explore an evolving relationship between the listed topics and the emerging themes, coming up with a series of thematic diagrams. It seemed that these GPs had several needs. They were interested in patients’ emotional factors, but perhaps felt ineffective in dealing with them. They
wanted to become more competent in counselling their patients, but realised they lacked the necessary skills. Because of this dissonance between abilities and perceived needs, some of them asked a supervisor for help. Others realised that they could not do more formal counselling unless they had an explicit arrangement for back up from the experts in this field, namely psychotherapists.

One analogy perhaps, could be a need to learn more surgical skills as a GP, and deciding to get specific coaching from a qualified surgeon. Eventually, having more surgical skills would rub-off on the rest of one’s practice, as it became an area of expertise and confidence. In getting supervision for counselling, these GPs all found that their confidence with ordinary patients increased, as they became more attuned to the underlying emotional factors in any patient, and became adept at dealing with those. The first version of the themes emerging from the data is outlined in Figure 5.8.

Figure 5.8 General themes, Version A

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Needs</th>
<th>Process</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Counselling; lack of prior training and confidence</td>
<td>Reflective practice using supervision: Discusses patients, situations, and inter-relationships between self and work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Interest in emotional factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cumulative effect of practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Personal issues impacting on work</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Role development as counsellor
- Career development
- Defines philosophy of practice
- Doctor-patient relationship becomes more important
- Increased confidence as GP
- Increased self-awareness
This diagram started with "needs," and then "reflective practice" was labelled as the process, or way of dealing with those needs. The outcomes were listed as role development, career development and so on.

However, this version did not explicitly include the idea of "dissonance" (between what should be happening in practice and what the GPs actually found to be the case). Because of such dissonance, these GPs explored various options and came up with a different model of practice, one based on reflection and interpersonal relationships. This version is shown next, and it demonstrates how a new philosophy of care works to resolve the deficiencies in training and expertise (Figure 5.9).

**Figure 5.9 General themes, Version B**

- **Deficiencies in training and practice**
  - Barriers
  - **Dissonance**
  - Needs of real practice

- **Resolution**
  - **Exploration**
  - **Reflective interpersonal practice** (based on supervision)

- **New philosophy of practice**
  - Roles of GP and counsellor more clearly defined
  - Career development
CHAPTER 5: Introduction to results

However when this second version was reviewed at the focus group, only some of the outline gained uncritical acceptance. An additional perspective was identified, as the concept of working in a “supervised practice”, in which the GPs not only reviewed their patients with the supervisor, but also discussed their own professional development. Supervision had became a forum for discussion on a wide variety of topics, including relationships with colleagues and with the wider medical community, with other spin-offs such as personal development and self-awareness. A supervised practice meant that their relationship with the supervisor was incorporated and integrated into their work on a daily basis, even if their contact with their supervisor was only fortnightly or even monthly.

The final organisation of themes for this thesis was then developed, as outlined below. The general themes are:

- **Dissonance and exploration** (Chapter 6)

- **Self-awareness and professional development** (Chapter 7)

- **The supervised practice** (Chapter 8)

- **Defining GP supervision** (Chapter 9).

These themes are illustrated schematically at the end of this chapter in Figure 5.12 on page 82, serving as a guide to understanding the relationships between all the topics and as a reference point when reading the next four chapters.

5.11 Research as narrative

The brief overviews of each participant at the beginning of this chapter were included for several reasons. Firstly, the process of unitization and development of themes seemed to be highly reductionist and fragmentary. By integrating the topics back into the individual diagrams, it was easier to see how each topic related to each GP’s
overall story. Secondly, while there are differences, the diagrams highlight the similarities of their experience, which leads to the generation of the thematic issues. Finally, one of the primary responsibilities in doing this research lies in doing justice to the participants and to honouring their contributions. Presenting only disembodied quotes did not seem to fulfil that obligation.

While these vignettes (and the subsequent analysis) present an outline, they do not represent anything like the whole story of these GPs’ experience of supervision, nor do they portray a full narrative as would be expected in more narrative-based research. Such research would need to have been planned from the start, and would have required perhaps several interviews with each participant. The focus would also have been more toward understanding their actions and choices in the context of their developmental, moral, emotional, and aesthetic concerns, with “story” being the central thread (Clandinin and Connelly, 1991). This research rather, focuses on supervision as a new concept in medical practice and the experiences of these GPs in their exploration of it. Despite these reservations, the experiences listed here are represented as an ongoing story or narrative of needs, barriers, and choices, leading to general discussion (throughout the subsequent chapters) on the current issues in general practice in modern culture.

Furthermore, the narrative presentation of the stories here facilitates an understanding of certain underlying tensions and ambiguities. All stories involve characters in a certain place, time and context; all stories also include the resolution of various pairs of binary opposites (Macquarrie, 1944). Stories become more engaging as the tension builds between such polarities as life versus death, potential versus actuality, individualisation of the self versus participation in the community, creative novelty versus tradition and habit, remaining private or hidden versus self-disclosure, and so on. The closer a story approximates one’s own ambiguities, the more one is drawn to, and affected by that story (Tillich, 1956). In this way readers of this thesis may be able to identify with the GPs presented here, finding some resonance with their struggles and their resolution of the difficulties in practice.
5.12 Presenting the topics and the themes

These research findings are located in several different, yet overlapping contexts. Firstly, as noted in Chapter 2, these GPs' experience is an example of supervision in one of the helping professions. Secondly, these experiences can be seen as responses to individual work-related stress, as well as part of an emerging narrative about their work. Thirdly, the setting for this is the culture of general practice in New Zealand, which has a particular history and epistemology, outlined in Chapter 3. Lastly, this research, and the experiences listed, are examples of a social constructivist philosophical paradigm, as outlined also in Chapter 3. Figure 5.10 shows the inherent tension in juggling these various contexts in the presentation of these findings.

Figure 5.10 The careful juggler
The method of presentation of findings is as follows. All quotes will be in italics; this includes the questions and comments from the interviewer who is marked in **bold**. Quotes are also indented and in single spacing to demarcate them from the rest of the text. Short interviewer comments (for example, *Mmm*) are sometimes included within the quote from the respondent. Words that are emphasised by the talker are underlined, and laughter and pauses are noted in parentheses. Names preceded by F/ indicate that the quote was taken from the Focus group (for example, F/Robyn).

Extended quotes from the respondents are used at times for the following reasons. Firstly, the interview process was one of mutual exploration of personal narratives and complex issues; some of the longer quotes illustrate this interactive process by including questions and comments from the researcher. This locates these findings in the interview method. Secondly, the quotes give the respondents an adequate voice; brief quotes out of context would not allow them to speak for themselves on these issues. This is summarised in Figure 5.11, where the transfer of authority from respondent to the eventual reader of this research is mediated by the researcher.

**Figure 5.11 The transfer of authority in interview research**

```
The transfer of authority

Respondent (who speaks for him/herself)  ➔  Researcher  ➔  Reader (who can make his/her own interpretations from the data)
```

Authority here is linked to personal authorship of statements by the respondents, while the reader has a personal responsibility to integrate the findings in light of his/her own experience. The role of the researcher is to provide the bridge between the two, hence the choice at times, of relatively long quotes.
CHAPTER 5: Introduction to results

Figure 5.12 General themes and topics (Version C)

Dissonance and exploration (Chapter 6)
1. Counselling back-up
2. The cumulative effect of a busy practice
3. Specific issues
4. Practice management and peer relationships
5. Validation
6. The barriers to receiving supervision
7. Choosing and changing the supervisor
8. Relief

Self-awareness and professional development (Chapter 7)
1. Challenge with safety
2. Effect on self-awareness
3. Career development
4. Wounded healer
5. Becoming a supervisor themselves

The supervised practice (Chapter 8)
1. The set-up in practice
2. Addressing both the physical and psychological aspects of general practice
3. “Shifting” patients
4. The doctor-patient relationship
5. The doctor-supervisor relationship
6. Reflective practice and experiential learning
7. Roles and boundaries
8. GP as healer

Defining GP supervision (Chapter 9)
1. One to one supervision versus group supervision
2. One-to-one supervision compared to a peer group
3. Supervision compared with personal psychotherapy
4. The system of GP supervision
5. Focus points in supervision
6. Roles of the supervisor
7. The definition of supervision in general practice
CHAPTER 6: Dissonance and exploration

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

The scene is now (at last) set to identify and discuss what the respondents actually said in their interviews and in the focus group. This is divided into four chapters, with this first chapter discussing the theme of dissonance and exploration. The following sections are dealt with in turn: Counselling back-up, the cumulative effect of a busy practice, specific issues, practice management and peer relationships, personal validation, the barriers to receiving supervision, choosing and changing the supervisor, and relief. These form the basis of a fascinating narrative, in which the main characters identified some learning needs, and embarked on their personal journeys of exploration. Hurdles were encountered, and some unexpected benefits were the result.

6.1 Counselling back-up

One of the main areas of learning for these GPs was counselling or psychotherapy in general practice. They had all been in practice for some time before they approached a supervisor to be supervised. While GPs in general have less psychological sophistication than experienced counsellors or psychotherapists, they still have to deal with psychologically demanding patients on a day to day basis. This includes patients with diagnosable psychiatric syndromes, but perhaps more commonly, there are many patients who have difficulties on an interpersonal level. As well, there is the "somatising" patient (as noted in Chapter 3), who is a real challenge to the modern practitioner if he or she is unaware of the links between mind and body, or the limitations of the traditional dualistic framework. Perhaps also, these GPs were responding to a greater awareness in the medical community that focusing solely on biological determinants of illness is insufficient.

Wendy's account of how she started is as follows. Her emphasis was on how to incorporate counselling skills into the general practice setting.

Wendy: Well, I've always been interested in counselling, so I was also [pause] trying to get a feel for whether I wanted to do counselling within
CHAPTER 6: Dissonance and exploration

general practice, and learn some counselling skills – that's always been a subtext for me in doing supervision. It's to pick up some tips on how to be with people when they're in strife.

In contrast to some of the other doctors in this study, Wendy incorporated counselling into the normal 15-minute consultation.

I've never done formal counselling with patients. I've never dealt with triple S. I've never sat down with someone for half an hour and said 'let's do counselling', but the nature of my practice – which is very heavily psychosocial – means that I, in a way, sort of do counselling, and try and jam it into fifteen minute slots, which is a dumb idea, but that's what I've always attempted to do. And the process has accumulated over many weeks of sort of, fifteen-minute blocks. I always denied that I did counselling, but my supervisors have always confronted me with the fact that I should be.

She acknowledged the difficulties of the task.

Wendy: And I found it very challenging, so I had supervision, and I found it really interesting to get into interpersonal dynamics and try and help people with their psychological problems, 'cause it's hard. It's much harder than doing wedge re-sections, and dermatitis. It's definitely always been a challenging edge.

So this GP had a learning need in practice that was not being met. She needed back up for the counselling side of her practice. The focus point for this is on the doctor's medical skills and activities. Other doctor's stories were similar. Robyn realised there was a “hole” in her practice, so deliberately chose a supervisor to help her fill that need.

Robyn: And I was working up here, two full days a week, and so what happened, was that I realised that there was this hole in my practice that I wanted to fill in terms of psychotherapy, and it was a holistic thing. You know, I was thinking that GPs should be able, need to be able to address people's psychological needs, as well as their physical needs, so I needed to learn how to do that.

However, she differentiated between counselling as part of normal general practice and the activities of psychotherapy.
Robyn: yeah, I could see all these people, who were, to me, screaming out for a bit of interventive psychotherapy, and I knew I had some skills, I had counselling skills, speaking skills, but I didn't actually have psychotherapy skills, and so I thought I needed to learn those.

Robyn then discussed this choice of learning method.

So I went off and picked on this supervisor, 'cause I knew him, and discussed with him, whether he would be willing to start a collaborative process of supervision and teaching, which was teaching me psychotherapy skills, and supervising me in the use of them. And that's how it started.  

So why did you choose supervision? Why not go to an advanced learning course?  

'Cause [pause], two things I guess – I'm not very enamoured of courses, especially since I didn't think that it would fill the need that I had, in the sense that I wanted it within the general practice framework. So I wanted to be using psychotherapy techniques within a general practice framework – and I didn't think I lacked counselling techniques, but what I wanted was psychotherapy skills; that's different– they're different.  

And I had a planning session with (my supervisor) about what my options could be, you know... because if I was going to be doing psychotherapy in my general practice, I needed a supervisor.

For her, counselling was different to psychotherapy. This quote also demonstrated how she made a conscious choice about her method of learning. This illustrates two recurring themes in this thesis. Firstly, these GPs were quite proactive about their learning needs, and secondly, they were aware of their likes and dislikes in medical education (perhaps as part of a wider self-awareness).

The role of the supervisor here is mostly that of a “teacher”. As teacher, the supervisor observes the supervisee in his/her work by audiotape or by self-report, and advises and instructs from his/her own well-established theoretical and practical base. This also involves an evaluative role; the supervisor needs to give feedback to the doctor on his/her skills and performance in light of their stage in professional development and previously established goals.

David’s entry into supervision was different again, and his narrative about his entry into this field revealed the gradual process of enculturation into a different mode of practice. He first attended a CME course on somatisation, and then joined a GP
listening-skills training group; this developed later into a supervision group for their counselling cases. Note also his views on psychiatric training, which had not met his general practice needs.

Why did you start supervision when you had been in practice for a number of years?
Yes, (I attended) some lectures on a post-graduate programme for GPs on somatisation. And it was the first relevant stuff I'd heard on the relationship of psychological problems to the physical problems my patients present with, that was putting the two together, um, and the psychiatric medicine up to that point was a complete waste of time in terms of dealing with the sort of thing I, and every GP finds in their practice.
So, after those lectures, there was a lot of interest, and, (the course leader) offered an advanced listening skills course which ran over about seven or eight weeks, for two hours a night once a week, and that was very, very good. It just whetted my appetite for psychotherapy, so I could take those listening skills on further, and particularly with a focus to exploring the psychological issues of patients who are presenting with physical problems, rather than psychological problems as the up-front presentation.
And so there were enough people to start up a couple of supervision groups and I was in one of them, and it was looking very much at those sort of issues, particularly in a general practice context.
So, that was very useful, I needed the supervision to help me with the counselling and psychotherapy side of things primarily, so it had that focus rather than a focus on day to day general practice stuff...

He used supervision for his psychotherapy patients, but as will be seen later, there were large spin-offs for the rest of his patients as well. Lee had a similar story, at least initially, to David.

What made you decide (to have supervision)?
Because I'd been going to a GP group of GPs interested in counselling, so it was kind of like a learning psychotherapy and supervision type group; and Over that time, I'd taken on a client or two, and then that finished. And then there was a period of time when I wasn't having any supervision, but I was carrying on doing the counselling, and I'd um, I came to a point when I needed to actually have supervision, if I was going to carry on that sort of work.

Lee explained the lack of back-up in general practice for this sort of work.

It's more like a sort of - getting something that was lacking, or having some back-up that I hadn't had.
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Her decision was quite clear; to hold dedicated counselling sessions (the other doctors above call that psychotherapy) she needed formal back-up.

Well, I suppose it's like... feeling I was taking on something that I wasn't fully qualified for, but, I mean, all the messages around me, from the other GPs and things, were that it was okay to do that, and they seemed to be doing it confidently. But I didn't feel confident, so it was like, I felt like I needed some extra confidence to be able to do that, without feeling like I was trained in that area, and I needed to. Yeah. And I wanted to move into that area, so this was something that I needed.

She experienced similar spin-offs to David.

But, in fact, probably when I started the supervision, I got more than I expected, because I got the benefits for the rest of my general practice.

So these GPs entered supervision to meet their respective learning needs. They differed on their definitions of counselling and psychotherapy, but all demonstrated considerable volition in their exploration to find ways of meeting the psychological needs of their patients. Their initial experiences were oriented around meeting the needs of others by becoming more proficient psychologically, but as shown above, there were some positive outcomes for the rest of their practice as well. As it turns out, those spin-offs were just the start of quite complex shifts in their approach to general practice.

Their initial experiences of finding or discovering for themselves the concept of supervision as a medium for getting professional help is unique in the literature on supervision. In other contexts, the experience of such supervisees is more about their learning as neophyte counsellors, including their interactions with various supervisors. (See for example, Battye, 1991; Moore 1991, and many individual quotes in Hawkins and Shohet, 1989; Williams, 1995). In these reports, the supervisees’ intentions to become counsellors were taken for granted and were not reported on specifically. Even in the closest work to this thesis, that of Freeman, (1998), the supervisees were invited to participate in an externally organised project, and so did not dream up the idea de novo.
In summary of this first section, these GPs had learning needs in practice that were not being met. They needed back up for the counselling side of their practice and they chose supervision as a vehicle to meet those needs.

6.2 The cumulative effect

Although their primary purpose may have been to gain some counselling skills, these GPs quite quickly realised that the supervisor could offer help and encouragement by taking a wider focus than just reviewing patients. These GPs then used supervision to process the cumulative effect of professional life. John had a heavy workload and found it quite stressful at times.

John: We target poor people, so we've got a lot of family violence a lot at risk kids and the workload is potentially quite stressful...it was just the load that we carried and it can be quite tiresome.

Similarly, Lee used the supervisor to sort through the overall effect of a busy practice.

I think what I find with general practice more, is that it's the cumulative effect of a whole lot of people that stresses me most. I've taken that kind of thing, like I'll take a list of a whole afternoon that's really left me feeling just wrung-out....

It's more often the cumulative effect of a whole session and how I can manage that, because there might be one stress from one thing, and combined with the time stress, and just the whole lot of pressures that are on me, that really get me most.

Sometimes we discover after a session like this, I identify one or two stressful patients that I have been unable to process at all in the flow of a GP afternoon.

So for Lee, supervision has a wider focus than just the need to review the patients that came for counselling.

And what were your initial experiences of your first few sessions of supervision?

Lee: It was, um, just wonderful to have [laughter] - you know, I was looking back through some of my old notes, actually, and it was just like a great relief, to feel like I had some back-up, and somewhere to take difficult problems and situations from the practice, as well as from counselling.

Paul used supervision to keep things in perspective.
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Paul: I think it's another way of monitoring yourself, cause I think it's very easy... You just get busier and you get tired and you just... You've got family issues and to just keep things in perspective, and have someone else observing and saying well this is how they see it, from where they're sitting. Keeps you on track.

He admitted that there were times when he wasn't coping.

Paul: And there were other issues which were impinging on my, there was, you do a hard day's work and then you, you, you'd be out, I'd be going to meetings at night, and I just um, got pretty rattled and not, not coping really.

The focus in supervision here is on the "state" of the doctor, using state in its widest sense. This focus immediately differentiates this general practice supervision from the first ("case-centred") model of Hunt (1986) noted on page 10. As it turns out, all the GPs in this study used a combination of helper-centred and interactive models of supervision. The main roles of the supervisor here are firstly as "facilitator", to provide the opportunity for the doctor to express and process feelings about patients and other situations. Taking a broader view as well, the supervisor's role is to be aware of the wider systems (medical and organisational) that the doctor is part of, and how s/he can adapt and cope with those external pressures. This role could perhaps be described as a "systems analyst".

Wendy also presents much more to the supervisor than "just patients".

Wendy: I think some of the things that came up, that I've presented – both at Balint groups, and in supervision – have nothing to do with patients, but relationships with business partners, with staff, with colleagues, with the whole notion of what people want from a GP...

If this is the case, how do other GPs review or process the cumulative effect of practice in the absence of such a sounding board? In retrospect, one of the doctors here noticed the difference to his working life when he didn't have supervision.

I mean (working in that place) was very stressful, and I had no supervision there at all. Except I used to go and see the bishop. But he really couldn't help me with... with your medical work... no, that's right.

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Getting help from the bishop for life-issues was perhaps helpful, but the need to review issues at work remained. Various other uses of supervision were also reviewed at the focus group.

*I think that from what I've heard in the last few minutes, it's multi-facetted. In fact I get different things on different supervisory sessions. Quite different.*

*Yeah, fair enough.*

Some of those facets are listed here in this excellent summary from Mark in the Focus group. These comments arose in the context of some complex discussion on how supervision is integrated into their practice of medicine. The topics are named in normal print in parentheses.

*Well I mean, this is very powerful stuff, this. Any comments from you Mark?*

*F/Mark: Yeah, I can understand all that. I've been thinking actually back to what Paul was saying about what I get out of supervision. And as a whole situation it's simply an opportunity with protected time to reflect because I find I spend so much of my life thinking about more than one thing or more than five things at a time, which is so typical of our condition and it's, to have that time aside to go deep, I treasure enormously. (Opportunity for reflection.) And as I mentioned in our interview Hamish, that a lot of the time it's not necessarily dissonance that I'm trying to deal with, but a need to challenge myself by saying okay I think I know what's going on here. But maybe there's a completely different view, a completely different perspective, to rock my complacency, if you like. And go exploring further there. (The need to be challenged.) Otherwise I'll just quietly go on doing what I'm doing in a non-critical manner, not because I don't want to be critical and you know during my time in being with patients, and clients and colleagues, I'm very aware of the emotional and social flux that goes on at the same time. (The cumulative effect.) I don't deal with it at that time usually, and the opportunity to have protected time to reflect on it is really treasured. (The need for self-reflection.) And of course the, okay, what is it about it that allows that? Well, the trusted colleague... that accepting feedback and reflection that the one on one allows, is what I really treasure. (The supervisor-supervisee relationship.) And where I discover in that process that difference that you're talking about, of um, the rebellious in me which says 'come on, there's a hell of a lot of nonsense out there in trying to categorise medicine and categorise this and the other', and getting an opportunity to be affirmed, even if it's different from any other people, my constructs are congruent as they stand and as long as they work for me, go for it. (Validation).*

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6.3 Specific issues

These GPs also used their supervisor to review some specific difficulties of professional practice. For example, Wendy used the supervisor as back up for teaching medical students. In the beginning as a teacher, she struggled with the idea that the teacher is different and separate to the students. This touches on the concept of “functional difference” between the teacher and student; as well as being supportive and being mutually involved with the student, the teacher must also retain some distance to be able to evaluate objectively. There is a parallel here with the need for both mutuality and functional difference between the supervisor and supervisee, and this will be explored in the section on the relationship between the two.

Wendy: I wanted to be friends with my students, and wanted to be equal with my students, and I mean, I was tempted to drop out of supervision, ‘cause I was having less and less trouble managing with my patients, and then as soon as I started teaching, I found a whole new lease on life in supervision. I certainly think teachers should have some form of – yeah, I’ve also used supervision to develop my role as a group facilitator.

Paul in the focus group moved in this discussion from “certain issues” in practice to more global concerns about the reality of practice.

F/Paul: I guess it started with a feeling that you know I would be concerned about certain issues and I wasn’t sure how to resolve them, and then I started having supervision and it was, it was just amazing how it helped to sort things out really. And then you realise that some of these concerns you had, were the reality of the practice and whereas before you thought ‘this is crazy, am I losing the plot?’

Another specific issue was with elderly women patients. Being on call to visit the elderly can be a drain, and GPs need to learn different strategies of coping with this demand. In response to this disturbing motive, one restrictive solution could be to stop doing visits without a critical review of the issues. A more enabling solution would be to explore why these patients in particular were so problematic. This deals with both the reactive fear (looking at oneself), as well as resolving or satisfying to some degree the original problem.

Paul: Mm, Yeah. And the other thing was that I was doing a lot of visiting. And I had issues with (pause) elderly women. (pause). I couldn’t (pause), it was like, um, as if I seemed to be the only person who ever went and saw these
people. Mmm. And, then in the end there was a sort of a, if I was late, they
would say oh, you’re half an hour late today, Doctor. Mmm.
And I thought, this is crazy, there’s something wrong, what is going on here,
what am I doing? Am I, (big breath), am I their sort of surrogate whatever?
Mmm. You know, am I really doing medicine? What is this all about?
(Pause). Then I felt guilty if I didn’t go and see them. And I needed ... I felt I
needed some help, and that, that, (pause). And so, those were the sorts of
starting points, like saying ‘no’.

Learning to say “no” by exploring these issues with the supervisor became the
creative solution. Similarly, after a personal crisis, Paul used supervision for specific
ongoing support for his work.

Paul: I guess that really took my confidence away...And if I hadn’t had
supervision, I don’t know quite where I would have finished up... The
supervision was incredible really, in that time.
I just lost it; I couldn’t get it all together. But what I guess I’m saying is that
supervision was just critical at that time. Absolutely critical. Because it did
enable me to... it was like as if...it gave me the strength and the courage really
to be able to say to the staff, ‘look I don’t particularly want to do too much psy(ological medicine) at the moment.
Because I’d actually been picking up a lot of...(laughter), I really just wanted
to see someone with a sore throat. So I was really happy to work the acute
clinics, and stuff that didn’t need too much um... for a few months anyway,
until I got back on track. Just seeing the supervisor once a week, once a
fortnight, yeah, I think we might have increased it to once a week. It was
superb.

Lee had been developing a role as leader of psychotherapeutic groups and used the
supervisor as a resource person.

Lee: I was focusing more on the group work, and I suppose I was having
supervision for the group work too. It wasn’t all career development. You
know, actually there was quite a bit on group work.

John explained how he used the supervisor to review certain situations at work that he
found stressful; for example, the death of a baby.

John: Well, I had my monthly appointment and at each monthly appointment I
would sit down and work out what I wanted to discuss at the monthly meeting
and at that meeting I can’t remember exact details at the time, but I’m sure I
would have arrived saying, ‘this is what I need to talk about today, I’m all cut
up because a baby died and part of me feels I should have saved that baby, it’s
all my fault.’
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Another part of me knows that there probably wasn’t much I could have done, well that I did a reasonable job at the time that I saw the baby and the useful thing that came out of that discussion was that in terms of what could I learn from this, the thing that I haven’t seen that they were a pacific island family and I did not explicitly check how much she understood of what I had told her, in terms of what to do if the baby got sicker. That may have made a small amount of difference and I’m not beating myself up for having not done that, but in terms of the supervision process that was a really useful little bit to have identified, you know, what would you do different next time.

Paul had used supervision as professional support for several years, so when he was the subject of a complaint from a patient, he had a structure in place to process that experience. At that point in time, he had been in supervision for several years and his personal response to the complaint was contained within the supervisory relationship. By contrast, the GPs in Cunningham’s study were afflicted with shame (as their primary response to the complaint) and many made substantial changes to their style of practice as a result of the whole process (Cunningham, 1999).

Paul: yep, I’ve been involved with Mrs Stent, but I haven’t.... Well that was very helpful then, the supervision for that, realising what a nonsense it was, getting some insights, and talking it through. Took two years to resolve it, and then it all just fizzled out.

So these GPs quickly realised that the supervisor could help them sort out work-related issues, which range from the elderly demanding patient, to being a resource for group leadership, to coping with disciplinary complaints. Specific difficulties of practice seemed to be legitimate material to take to supervision.

6.4 Practice management and peer relationships

Learning to work in collaborative ways with colleagues is unfortunately not a “given” in the medical community, and many GPs report how practice management (relationships with staff, and business management) are sources of ongoing stress. The origins of this could relate to the competitive methods of entering medical school, the “Lone Ranger” syndrome so prevalent in medical cultures, or even the pre-morbid personalities of medical students (Revel, 1995; Vaillant et al, 1972). All the GPs in this study mentioned interpersonal relationships with colleagues as being stressful at
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times. John, for example, used the supervisor to specifically review his ongoing difficult relationship with a colleague.

_The biggest issue that I have used over the two years has been a relationship between myself and one of my medical colleagues at work, which is fractious and has had a number of difficult blips to it. I never would have dealt with it had I not had a supervisor because I would end up at a session with nothing particularly on the top of my head except the fact that I was pissed off with (my colleague) about something or other._

The outcomes of having supervision were as follows.

_Yup, well it also helped me how to respond and how to be constructive in my responses and how to work out problems rather than up the anti, and to be able to try and look at what (the colleague's) position was and to be able to see it wasn't all malice, (laughter) and possibly not any malice. A function of the way (the colleague's) brain works which is different to the way that mine works._

Similarly, Mark in the focus group compared his current “source of succour” with his current stress.

_F/Mark: I must say that on that, just as we talk, my patient contact is generally my source of succour. It's where I enjoy life, I enjoy life in a consultant room, particularly with counselling. And most of the dissonance comes from the practice management side. It's interesting that I... I haven't been used to bringing practice management to my psychotherapy supervision, but it does cause me the most pain._

In this context, the individual doctor's relationships in the practice were the problem, and this seems to be very common in the general practice community. Robyn continued this theme in the focus group:

_F/Robyn: No, I'd have to say you're right. I actually take my practice management to supervision, more recently... I didn't think that was sort of such a valid thing to be taking to supervision, however. And it... I have actually discovered that it's much more challenging to try and talk about what's going on in practice management and interpersonal relationships within the practice. Mark: Yeah. Robyn: Than to talk about your easy peasy stuff, of dealing with the patient. Mark: (Laughter) Absolutely, yeah._

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They agreed on just how hard it is to resolve some of these issues, and in her interview, Robyn gave an example.

Robyn: In a particular situation, a couple of years ago, where I had some problems with a colleague that I was working with, which was quite difficult, it was important to be able to talk out what to do. [pause], and once more, it was the same thing. Like, I talked about that with other colleagues, about what I should do (as well as discussing it in supervision).

Mark widened this to include the medical community in general.

But if I think about where is dissonance in my practice, I think of the powers that surround me and my sense of hopelessness.

This GP’s relationship to the wider medical community was also the source of a disturbing motive (his “dissonance”). In sociometric terms, the wider medical community acts as the enveloping group for the individual, even though the group never actually exists in concrete terms. “The powers that surround me and my sense of hopelessness” seems to refer to certain medico-political directions in New Zealand at present, and this GP felt unable to effect change within it.

He was not the only one in this study whose sociometric relationships to the medical community were at times a source of discomfort rather than of support. Lee also used the supervisor to review her relationships with her peers and to the wider community in general.

Lee: I haven’t so much talked about counselling as clients for the year. A lot about dealing with my peers in medicine. Yeah, that’s right, and it’s been a big thing I’ve worked at in supervision actually...is being able to be okay in medical groups...And develop roles that enable me to feel okay, and get what I want to out of peer groups.

She was clearly aware of the concept of roles. An important distinction is that her problems with the group may not be due to specific group issues; rather, that her role in relation to the group was problematic. She had been talking about the local Balint group.

Lee: I suppose, in retrospect, I felt a lot of shame in that group, and felt like I wasn’t able to produce what was required, or if I did, I felt too exposed, and so I didn’t feel good about presenting stuff.
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I quite liked hearing other people discuss stuff, but I didn’t feel I could express my opinions very well, but then, that’s always a difficulty for me...

The problematic role could have been entitled “The Naked Presenter”, or perhaps “The Shameful Exhibitor”. From her role cluster, the group acts as “The Critical Consultant,” even if in reality the individual members of the group were warm and supportive to her. Working through this sociometric analysis allowed her to eventually function more profitably in those groups. This particular role clustering may have originated in medical school, where in the 1970s female medical students were exposed to some particularly critical consultants (Egan, A: personal communication).

Another source of difficulty can be the need to perform managerial duties, given this cultural background of intra-professional conflict. Paul had a role as director of an agency, where he encountered considerable difficulties with staff.

Paul: And there were lots of issues with staff... You know, when some staff got, lost their marbles and would come raging to my office, and swear at me. It was the doctors. Amazing stuff. And I think god, what have I stuffed up there? But again to take that to supervision and realise that it wasn’t actually my problem, it was the other person’s problem really.

The value of supervision in those situations was as follows.

I think what supervision did for me...was to have another person to talk to about it, and to realise I wasn’t doing a bad job. That I hadn’t stuffed up. That I was actually doing okay, and we were dealing with very difficult things. It was like some reassurance and some permission to carry on with what I was attempting to do. To keep exploring it... Keep exploring it...

Winnicot’s notion of the “good enough” mother is relevant here (Winnicot, 1965). Paul’s role of being the good enough manager was achieved by being supported and held within the supervisory relationship.

To summarise this section, these GPs used supervision to review practice management and their relationship with the wider medical community. Sociometric analysis helps to understand their roles in relation to the group (Logeman, 1999), and this approach avoids blaming external factors “out there”. The focus is then back on the individual where self-awareness and personal choices can be validated. This leads
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to the next section on validation, where once again the focus point in the supervision process is on the doctor’s state.

6.5 Validation

Both explicit and implicit cultural norms and rules usually bind groups (in this case the NZ medical “group”). These may vary over time, but cultures exhibit remarkable homeostasis for long periods. These GPs, as already noted, were an outlying group from the mainstream. They used a method of professional support that most of the medical community has not even heard of. Furthermore, they were conscious of being different, and they were quite articulate about their philosophies of medicine. This raises some general questions: How much does a practising health professional need to be told that he/she is doing ok, or even further, performing very well? Is this even more important if the helper feels different to his or her peers?

For example, in the focus group there was some discussion about using “Read Codes”, where a code for a disease is required to label each consultation. The discussion is reported in full, as it demonstrates the style of the focus group; mainly serious, but with flashes of humour.

F/Paul: And you may even get into points where you’re not actually necessarily agreeing about what maybe you should be doing. But you will also be discussing it with your supervisor because that’s, if you like, that brings up some sort of ‘conflict’ that you feel you need to discuss with your supervisor to get some reassurance that you’re on the right track or that you’re right off it.

Mmm, the phrase that came up recently was cognitive restructuring. Is that what you’re actually doing there?

F/Paul: Brainwashing. (Laughter from others).

I mean you’re taking something that’s actually potentially quite problematic, and reviewing it in a different light, yeah ‘brainwashing’.

F/Paul: Yeah, no, I don’t think it is brainwashing, it is actually...I mean I think it’s a constructive re, yeah a cognitive.... Yeah it’s a new way of looking at it, or another... or a way that fits really, I guess. You’re coming up with a another way, a cognitive reconstruction, it’s not really brainwashing, that’s a bad word really.

Okay, so going back to dissonance....one way of resolving that dissonance is to reflect on it.

F/Paul: Yes, reflect and you know, talk about it, and that’s where I find that supervision is a place where you can throw that around without.... Cause sometimes it’s quite threatening to your colleagues if you actually, you know,
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say the whole things crazy, it’s not going to work, or that it’s... I mean you need a forum where you can.... A place where you can actually say these things and actually get someone to throw it back at you and reflect on it, you know what I mean?

So supervision was a forum where they could say “the whole things crazy”, and still be affirmed by a respected health professional. Although Lee was not at the focus group, she had already confirmed the value of validation in her own interview. In some respects, Lee felt different to the rest of her peer group.

Lee: I suppose I feel personally supported, and I [pause], it’s where I feel my approach is valid, or something. Validated yeah, I suppose I’ve got much more of a – my mind-body bent than most of my peer group, psychotherapy-counselling type approach than my peer group. So, I’m coming from a different point, and therefore, that gets supported in my supervision. But, I feel like a fish out of water at times in my peer group, because they don’t think or look at things in the same way... That really puts me out on a limb, so I need support [laughter].

She summarised this as follows.

Lee: Having real back up, somewhere where I can be really honest about what the problems I’m facing are, and so despite those being in the open, I still feel okay about my work and you know, it helps me see what I’m doing and how I’m doing it, and be overall clearer, and feel supported.

Affirmation was also important to Paul, and he went further to link that affirmation to the importance of “not trivialising” one’s work.

Paul: Well, what it does is it affirms me, in terms of what I’m doing. It gives value to what I’m doing... in all our work we can, think we can trivialise what we’re doing, and when you start talking about the person who comes in with a sore throat, who you can’t sort out, and they’re just wanting something and you’re not sure what. When you talk to a person, like your supervisor, or your, or with the psychotherapy element, you realise this... there’s something very significant in these human encounters... to actually tease those out and look at them, you realise that hey, this is really something. This is really important. It’s not just trivial, it’s not just another sore throat. It’s something that’s got all sorts of other dimensions. And even if you like, reaffirming that is very important for me.

As helpers then, being validated is important. The job is difficult, there may not be much direct positive feedback from patients, and feeling that one is different to one’s peers can be another source of stress, and even alienation. Yet these GPs gave me the
impression of being positive, resourceful, and clear about their intentions with patients. They wanted not just to be told they were doing ok; they wanted to be critically examined and evaluated and if after that they felt ok about their job, then the feedback had been earned. In the culture of conformity of general practice in New Zealand and given the stresses on GPs here (Dowell et al, 1999), these attitudes seemed quite remarkable. Supervision here seemed to contribute to a “high morale,” probably stemming from ongoing use of roles such as facilitator or analyst over extended periods of time. One hypothesis is that these roles of the supervisor enable the supervisee to continually process intercurrent work issues and to re-define their day to day purpose of work. However, these attitudinal adjustments only occurred after considerable work. One of the main hurdles was to work through the barriers to supervision, as outlined in the next section.

6.6 The barriers to receiving supervision

These GPs worked through some significant barriers before they could receive the benefits of having supervision. This feature of supervision is one of the crucial aspects of this thesis, as it represents an intersection between the culture of medical practice in New Zealand, the generic principles of supervision in the helping professions, and an illustration of individual responses to stress. The background to this is the culture of learning in medical practice.

It is only recently that CME (continuing medical education) has become the norm in general practice. Before the 1980s however, the aphorism was probably true; one could either practice for 40 years, or else one could do the same year 40 times over! Once qualified one had a licence to practice; ongoing learning and critical self-evaluation of skills was considered unnecessary. In other helping professions (marriage guidance or psychotherapy, for example) the structure of supervision is integrated into the curriculum. One learns by apprenticeship from senior practitioners and it is a requirement of licensure that this teaching and monitoring method continues in practice. Although there are some barriers to getting good supervision in the other professions, the barriers described here are unique to medicine.
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Further, if the need to receive supervision is regarded as the motivating force, then it is the culture of practice that provides the reactive fear, which could paralyse the individual into remaining conflicted and in chronic unresolved stress. The following quotes illustrate these issues in practical terms. Firstly, these GPs were quite discreet about their use of supervision.

Do you tell other doctors that you use the supervision method? I mean, are you open about it?
Robyn: Well, my general GP peer group, I wouldn't dream of telling them about it.

Robyn felt it is the “culture” of general practice that provides one of the barriers to getting supervision.

What is the cultural thing in your practice that means your ordinary peers are not able to relate (to it)?
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 powergames, or one-up-man-ship. If you look at the littlest medical student, you go on rounds, and in the rounds, 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.

With this sort of indoctrination into a culture of “one-upmanship”, it is not surprising that going to someone else for advice is seen as sign of weakness, rather than as a creative learning option. This also means that there is little understanding about the concept of supervision.

This is raising an important issue then, that the concept of supervision is foreign to most doctors.
Lee: Yeah, it is. I think, yes. And they haven't warmed to the idea, despite me waxing on about the benefits over the years. Maybe also something to do with difficulty in understanding roles and different roles- and the role of a supervisor – difficulty not seeing it as an authoritative judgmental role. 1
think doctors have very large self-critics and defend strongly against potential shaming situations and this could be seen as one – i.e. supervision. The word mentor gets over this to some degree, as it doesn’t have a judging quality. I think it is hard to grasp that a supervisor takes a different role and is in no way superior or a judge, but helps the supervisee to see more clearly by having another perspective.

Is that one of the barriers to the medical profession having supervision? Can you clarify that further?
Lee: I think lack of concept of it, and a lack of seeing the benefits of it, not able to see the need for it.

The focus group discussed a recent example of this type of culture at a conference presentation.

F/Mark: Once more this came up at that conference, that I mentioned before. Because there were a few people there who are involved in supervision, and a whole room full of people who were pretty horrified by the thought of it. Wouldn’t you say that was a fair evaluation?
Mark: Are you talking about the last conference?
Robyn: Yeah. You know that session that we had.
Mark: Oh yeah.
Robyn: Remember when we were discussing how to deal with...
Mark: Adolescents...
Robyn: Adolescents and... I said; “you know this is, this is just the situation that I deal with in supervision”, and (the presenter) said she “couldn’t imagine being in her practice without supervision”. And I had quite lengthy conversations with people that spun-out of that saying; “what a waste of time”.
Mark: Really?
Robyn: Yeah, all the usual things.
Mark: It’s interesting I’ve never come up against resistance to it, just non involvement really. I don’t talk about my supervision much I suppose. I mean I mention it to people, and they say ‘oh yeah’ and carry on. No one’s ever come up and said ‘Tell me more about this’, which is interesting.

So the range of responses here is from disinterest to active horror. If these views were enculturated into a community, then individual opinions would reflect that. GPs deciding to have supervision would need to work through their own “horror” before it would be possible to begin. Much of the horror mentioned by Robyn above could be the perception that supervision is threatening.

F/Paul: Yeah, it could be threatening to some. After all supervision doesn’t always produce warm fuzzies, I mean, or... It doesn’t always...I mean there are sometimes things that we bring back from supervision and we really have
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to think hard about perhaps the way we've been approaching things and feeling about the system, bla, bla bla, and so we may have to make changes.

David acknowledged the threat was more perceived than real.

Okay, going back to when you first started doing supervision, it was in a small peer group. Were there barriers to doing that?

David: A bit of anxiety of who else might be in the group [laughter]. Yeah, there were barriers, the barriers were mine, my own personal issues, and insecurities, and 'what will other people think of me', and you get the most benefit out of supervision if you're straight up, and let it all hang out, more or less, as much as you're able, and I had some anxieties about that.

So yeah, the sense of threat, and how charitable or uncharitable will other people be when I tell them, you know, how I really am, what I really am, where I'm really at, and the way I deal with problems in my practice, which obviously affects me to a large extent. So, yeah it is putting yourself out there, it felt a bit like that.

It's quite a vulnerable situation.

David: Yes it is. There is an element of vulnerability, I'm sure you can do it by being not very vulnerable, but that means that you get not very much out of it too.

Talking about one's work is genuinely exposing of oneself, and the medical culture has coped with this (so far at least) by adopting a code of silence about one's style of work. To some extent in general practice this tradition is changing, perhaps as a consequence of the large number of peer groups, where more frank disclosure about one's work is becoming more common. John linked the issues of vulnerability and of "not knowing" in this quote.

I think that whole issue of being able to be vulnerable, because it's no use unless you're honest, if it actually hasn't got painful enough that you have to be honest about it and your still drinking to deal with it, or whatever it might be that you do that's not constructive.

Then it costs money if you're in your own private practice, then that's money you're spending... It's also you need to learn how to use it, that I think depends on the quality of your supervisor, but also depends on where you're at in your professional development... I suspect at the beginning of practice there's a lot of focus all on the technical stuff, 'do I know enough about stuff' and that the things which feel uncomfortable will tend to be externalised because I don't know enough about them.

Rather than feeling you can fix it by actually being comfortable about not knowing.
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The connection here is that becoming comfortable with “not knowing” is an acquired skill. Until practitioners learn this skill, they feel vulnerable about their lack of knowledge but are often unable to admit it. This vulnerability seems to be endemic in medical circles. These issues are further discussed at the end of this chapter.

Others’ perceptions of supervision did not hold Paul back, however who paid for supervision himself, despite working in a salaried position and requesting a supervision subsidy.

Paul: And I actually paid for it myself initially, because the (funding body) said they’d never heard of such a thing. I spoke to (the Head of Department), well I asked for it, could it be paid for. He spoke; consulted with [another Head] I think it was who said he’d never heard of such things. Ridiculous..

Ridiculous, so, I mean what sort of wimp is that guy? (Laughter). So, it ah, it just got squashed. So I just went and paid for it myself, and it was well worth paying for. Cause we were in a very difficult time...

Mark explored these hurdles in more psychological terms.

Mark: You must remember that it’s all very well to have our defence mechanisms looking after our inner psyche, but those defence mechanisms are there for a purpose, and sometimes, people are saying ‘I live a very comfortable life, with my mechanisms, which help me to function’. Otherwise, you’re opening up the issue that we should all go through – not only therapy, but maybe analysis, to take ourselves apart so that we can be totally aware of who we are with our patients and clients. It’s far too dangerous.

Robyn also had to work through this threatening aspect before supervision became helpful. In retrospect, audio-taping her sessions for later discussion with the supervisor may have been a technique that was introduced too early. This extended and edited quote from her interview demonstrated how she worked through that initial vulnerability, until supervision became more comfortable.

Robyn: I mean, it was really threatening in the beginning...And the scariest thing that I did was tape some interviews and bring them into supervision, and talk about what was on the interviews [laughter] very scary.

So you found it threatening in the beginning?

Robyn: Yeah. My work practices were being exposed, and they weren’t just simple work processes, like – whether I’d prescribe penicillin or amoxil for a sore throat, which is a bit, to me, what the video interview for the college was like; but it was much more, I was taping me, in a psychotherapeutic environment with someone. So that was much more threatening.

And then you’d analyse it with him?
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Robyn: Mmm. Now, we did it in the beginning, and I really didn’t like it at all. It was really, really threatening. It was too early, I think it was too early in our supervision relationship to have done it. So, I’d be ok about it now.

It was threatening because?

Robyn: I wasn’t in control of telling him what had happened. Like, when you do (normal) supervision, you can edit [laughter]. When you have the audio-tape, you can’t say that you didn’t say that, or you can’t just not say what you didn’t say.

So that’s quite a brave thing to do there...

Robyn: oh, shit it was scary, and I think that, I mean, it was just a bit too much at the time. I mean, it was scary, but I did it – I’m good, I do what I’m told. He suggested I tape it, so I did what I was told.

But I wasn’t that happy about it, but I was gonna do it, because it was for my benefit, you know, I trusted that this was for my benefit, I was just very anxious about being exposed in my inadequacy.

The reason why I am hanging on to this is to learn how vulnerable were you when you first started supervision? I’m wondering if it is a barrier to doing supervision?

Robyn: Yeah, I suspect so. But it’s also the value of doing it. And it pushes you through. Well, it’s like a challenge, so a change has to happen in me, to allow me to continue that process, so either I had to get – improve my self-esteem – or whatever it was, that made me not so vulnerable.

The transcripts from the interviews had literally pages and pages of data on the barriers to getting supervision. For example, one of these GPs had to explain to other members of her peer group that their attendance there did not constitute being “supervised” (to qualify for the local Independent Practitioners Association counselling subsidy). This illustrated their lack of understanding of what supervision is; just having Lee there (who did have supervision) did not mean they were receiving it, even vicariously. There was also an idea that having supervision could imply that “you’ve got a problem”.

F/Mark: I agree there, in that people are rushing to peer groups, I mean partly because it’s a requirement in some respects. But they are all getting a lot out of it. Everyone I know talks warmly about their peer groups, but if you go to supervision that implies you’ve got a problem, rather than you’re thinking creatively out of the box, and ‘there’s got to be more to it than this, even if this is okay’. And I think that’s possible what taints the idea of one on one supervision. It’s too close to counselling cause ‘you’ve got a problem’.

This will be further explored in the section on differences between supervision and personal psychotherapy, but that perception remains another barrier to getting
supervision. In summary of this section, Robyn listed the overall barriers to getting supervision as a GP, and once again the topics are placed in normal print.

So what are the barriers to general practitioners to take on supervision as a mode of self-maintenance?

Robyn: Finding a supervisor would be one of the big steps. Understanding the need. See, the barrier that I suspect, is that not understanding what the benefits that come from it are. (The concept)

'Cause you have to put a lot of work into supervision. I mean, in my case, there's the travelling, and finding that bit of the month that I can actually take an afternoon off, and pay for it. And, either it eats into my work time, or it eats into my leisure time, so you have to value something quite a lot to do that. (Time and availability)

So, I think the main barrier – or one of the barriers that I see there – is, how you can get people to understand how good it is, without them having gone through the process for a while. So here's a barrier – it takes a while of being in supervision to get through the trusting, setting up, making it work well at the beginning, which can take some time, and GPs are busy people, who feel like they have lots of time demands on them and this is another work demand – it's like, why bother? (Commitment to the long term outcome)

At the focus group Mark wanted supervision to be seen in a more positive light.

F/Mark: And maybe we need to change that perspective and say this is just, well it's... So maybe there's the twist that we might need... we have an opportunity to start spreading. this is not for people with problems.

These quotes in this section have been reproduced at length because of the importance of the concept of barriers to supervision. Looking to the future, some of the barriers are now changing; medical schools are now using small group collaborative learning (Schwartz, Heath and Egan, 1994). Continuing medical education (CME) is well established, and individual styles of practice are more tolerated. However, the competitive methods of entry to medical schools remain, as does considerable reluctance on the part of most doctors to incorporate self-reflection and self-awareness as an integral part of their method of practice. Balint for example, introduced the concept of group supervision almost fifty years ago, yet Balint groups are still uncommon and one-to-one supervision still very rare. There is a long way to go before a culture of learning is the norm in general practice.
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6.7 Choosing and changing the supervisor

Because the concept of supervision is largely foreign in general practice, it is perhaps not surprising that these GPs searched for and found their supervisors in a related profession rather than in medicine. Each of them related a story of exploration; most of them had used several supervisors depending on their needs and purpose of using supervision at different times. The underlying consideration for all of these GPs in choosing a supervisor was the doctor-supervisor relationship.

In some of the other professions, the supervisor is allocated to the supervisee or trainee. Here, the onus was on the GP to find a suitable person for him/herself. As these GPs are rather more psychologically orientated than most, it is not surprising that their supervisors were mostly drawn from the ranks of psychotherapists. Some were also doctors, who had further specialised, but none, surprisingly, were psychiatrists. All of the supervisors were members of NZAP (New Zealand Association of Psychotherapists) or NZAC (New Zealand Association of Counsellors). These associations have increasingly rigorous admission criteria, and both require members to have supervision as part of membership. The step of choosing a supervisor was then the third step in starting supervision. Step one was to realise that it was needed; step two was to work through the cultural and personal barriers to getting external help, and step three was to choose a suitable person.

The consistent theme from the stories presented here was that the supervisor needed to have psychotherapeutic skills, although s/he could be a psychotherapist or a doctor. The following excerpts illustrate these issues in their ongoing choice of supervisor.

For example, Lee initially chose an experienced psychotherapist.

Why did you choose a psychotherapist to go to for supervision?
Lee: Because I was looking for supervision for my counselling work. Rather than with the general practice work.

How did you decide who's your supervisor?
Lee: I talked about it with my psychotherapist at the time.

You had an existing psychotherapist?
Lee: Well, I had somebody who I was seeing for a few sessions, who — so, I'd had this sort of, niggling need to have some kind of supervision, over the year since the group had stopped, and then I brought it up in one of these sessions, and she pointed me in the direction of (this supervisor).
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Oh right, you went to him for supervision? So, it was a different person to your psychotherapist. Could you have not just seen the psychotherapist?
Lee: No. No.

This is an important distinction, which will be explored further in the section on the difference between supervision and psychotherapy. David's initial choice was one of the teachers at the listening-skills seminar, and this quote shows how this decision was reviewed later.

And what made you decide to leave that (first supervisor)?
David: Ah, I think it was the lack of relationship actually, with my supervisor, who I saw as a [pause] probably [pause] not an especially warm kind of person. I mean, he was alright, but you know, I didn't feel he sort of, offered that much of himself, there was kind of a technical focus, which in this sense was the technology of therapy to some degree.
But, I wanted more of an interpersonal connection with him, which was not on offer. So, I'm not sure how important that would be to other people, but it was important to me, and I enjoy my supervision that I have now. It's a bit more... I'd met him socially, at a dinner party on one occasion, and I thought he was an interesting, warm, lively, intelligent, energetic person... which he is [laughter]...
So you stayed with him, and you've been with him for a while now.
David: Yeah, eighteen months or so.

What David is referring to above, is the supervisor-doctor relationship. He needed more than just "technical" support. In all of these narratives about their supervisors, the subtext was relationship. Later, the importance of this is demonstrated as part of the parallel processes between patient, doctor and supervisor.

Mark had had three supervisors over about eleven or twelve years, and his story reflected his different needs as well as his deepening appreciation of the complexities of the doctor-supervisor relationship. Robyn and Paul had stayed with one supervisor over many years; Robyn's reasons for not changing are outlined here.

Have you kept the same supervisor all the time?
Robyn: Each year we discuss the year's agenda. You know, what's the purpose in supervision for the next year? Should we change supervisors? And it's definitely been my choice to remain with the same supervisor, which has a number of arms to it really.
I think one of them, is a little bit chicken, from my part, in the sense that I have a very comfortable relationship with my supervisor, and I [pause], I trust that he won't [pause], I was gonna say, challenge me too hard, but that's not true
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'cause he challenges me enormously at times, but I trust that he will respect me – I think that's what it is.
And, [pause] developing that trust relationship takes time, and I'm not sure, well, I've been not willing to spend that time developing that trust relationship with another supervisor.
So being respected by your supervisor, and having trust with him, is an important part of your supervisory relationship.
Robyn: Absolutely.

John had also made a conscious decision not to change his supervisor, as the following quote explained.

It's interesting there was talk, not from her, but from one of the other staff members about how one ought change one's supervisor after a couple of years. My reaction to that it would be probably ok in that some of the time my supervisor is a bit predictable, but on the other hand a lot of the time there are things tripping me up are absolutely predictable and she's just challenging patterns that I have maintained. Certainly she's got a good understanding of how I tick, and her perceptions of how I ought to do things differently or suggestions or interpretations or whatever. By in large I still find it useful, if it wasn't I wouldn't keep going.
So she knows you pretty well now.
Yeah, I had a session yesterday and we ended up talking about (my colleague) again and I said something about being a bit bored by the fact that I've spent two years talking about this and it seems like a stuck record. She made the observation, which is absolutely true that I'm doing a lot better now than I was two years ago in terms of that relationship.

In their decision about their choice of supervisor, these doctors differentiated between the content and process of general practice, and the need for the supervisor to focus more on the latter. This was discussed at length in the focus group.

F/Mark: The trouble is as being GP's, there's a danger we get seduced into understanding too much about content. And talking and getting involved in content of the situation, which is why we go to psychotherapists for supervision ourselves. Because they don't deal with that shit. They deal with what's going on...
What's your views on that one, Paul?
F/Paul: Yeah, I think I agree about this business about process. I think the process thing is very important to me. So I can sort of understand it. You know why, how does things happen? Content is not so important, you know the hard stuff of practice. That would more, come up more in a peer group where you were actually talking about management of things.
F/Robyn: I mean, for me, I get distracted by the content in my own practice, and that's what gets in the way at times. I'm too busy thinking about the
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content and I've lost the perspective on the process, and I need to get the process sorted out, which is why I go to my supervisor.

Robyn felt the supervisor should not be a colleague, as that helped when she needed to discuss certain problems;

_Do you use supervision to talk about difficulties with colleagues?_  
Robyn: I use it. In a particular situation, a couple of years ago, where I had some problems with a colleague that I was working with, which was quite difficult... but once more, what was good was that the supervisor wasn't a colleague.

Yet Mark’s current supervisor is an ex-GP.

F/Mark: I purposely left a psychotherapist, and I currently have an ex-GP as my supervisor. Specifically because I thought it would be quite nice to deal with someone who actually understands my condition and what it's like to sit in that seat in that way.

Wendy commented on this topic in her interview, knowing that Mark was seeing that particular supervisor. This excerpt summarises this section on the qualities of the supervisor that these GPs feel are necessary.

_I'm asking what qualities a supervisor must bring?_  
Wendy: Well, a very thorough knowledge of the way in which health professionals interact with their clients, of any sort. What those issues are, what the red flags and the yellow flags are for just functioning in those relationships. Um, plenty of tools, like helping people to see, get insight, into what's happening. Um, very sound professional ethics, understandings of boundary issues.  
Shouldn't doctors have all those?  
Wendy: Well, I think it’s that you go to supervision to learn more of that sort of stuff, because we didn’t get a hell of a lot of it in our training. And, I don’t think many doctors have – particularly because in general practice there’s so much to do, that developing profound skills in those areas takes either great dedication over many years, and (Mark’s supervisor) is a good example, that he’s a GP who’s chosen to develop his own practice – I don’t think it’s an appropriate role for somebody who’s just dabbling in it.  
That, you need, a very solid basis of experience to be a supervisor. Although, I agree with you it doesn’t matter which discipline you start from; it’s the experiences that you’ve been given.

As Wendy has pointed out, the supervisor for these GPs needed to have thorough knowledge, sound ethics, awareness of boundary issues, and considerable experience; all in the service of the supervisee.
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In summary of this section, GPs chose and changed their supervisor depending on their specific need at the time, and the reputation of the supervisor. The supervisor needed to have psychotherapeutic skills, but could be a psychotherapist or a doctor. The underlying issue in all of these choices was the relationship between the doctor and supervisor.

6.8 Relief

Once these barriers were overcome, and a supervisor had been found, these GPs experienced considerable relief from talking safely about aspects of their work, and they gradually developed confidence in the supervision process. Lee reviewed her feeling of relief.

And, what were your initial experiences of your first few sessions of supervision?
Lee: It was, um, just wonderful to have [laughter] – you know, I was looking back through some of my old notes, actually, and it was just like a great relief, to feel like I had some back-up, and somewhere to take difficult problems and situations from the practice, as well as from counselling.

Can you explore that a bit more, that relief?
Lee: Um, [pause], yeah, well it was like, well I wasn’t working on my own. No, it was a huge relief, and I didn’t have that in the other groups I’d done, ‘cause I’d done the Balint group, and I’d done the other group – and that (the relief) wasn’t there, because there’s a lot of anxiety about presentation in a group, but with the individual stuff, it was just like – I don’t know how I can describe it more.

Going back about not being alone. Can you explore that a bit more?
Lee: Well, it was like, through the – I think I was going fortnightly, and it was like, through those two weeks, I knew that there was somewhere I could discuss any difficulties that arose, you know, so it was like the supervisor was always kind of present, and I could go through my head conversations, and I suppose I could even ring him, if necessary, although I never really needed to. It was really like, suddenly I felt like I had real back up, and somebody who knew me too.

Robyn also found that relief, but only after some hard work learning how to do psychotherapy...

So what changed? Did you develop more confidence?
Robyn: I guess there was a number of things. I [pause] did develop more confidence, but I developed more confidence because I saw good outcomes coming from (doing psychotherapy).
So, there was clear value in what I was doing. So even if I labelled myself as not very competent at this, I was getting good outcomes with the people I was
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working with – so I can’t have been that incompetent, otherwise I wouldn’t have been getting those outcomes.
I mean, part of supervision is that we try out little scenarios, different scenarios of how I might deal with the situation; so, I go back and try those out, and they work; and so then, I trust a bit more, in that non-directive type of process.
So, there was an evolution that had to take place, and as that evolution took place, then I became more confident in what I was doing, and then it wasn’t so threatening.

This ends the first sections of data from the respondents. So far in this narrative, most of these GPs realised that they needed back-up to do counselling or psychotherapy, and then they worked through a number of important barriers. They chose a supervisor, and as noted just above, they experienced considerable relief as well as a developing sense of confidence in their work. As a worked example of supervision in one of the helping professions, their experiences were unique, given that their use of supervision was entirely voluntary and rather uncommon in their professional culture. This chapter now continues with discussion on some of the themes in general practice supervision.

6.9 Learning psychotherapy and counselling
One of the more common entries into supervision for these GPs was the need to learn psychotherapy. This applied to Wendy, Robyn, David, Lee and Mark, whereas Paul and John started in supervision for other reasons. In all cases however, they reported how much more confident they had become with all their patients, not just those attending for psychotherapy. It is interesting to compare this group with the Dunedin cohort of GPs who are being surveyed in late 1999 about their interactions with psychiatric patients (Egan, personal communication). This latter group seem to be characterised by lack of confidence with those patients, most of them indicating they wanted further training. Admittedly, those patients needing counselling (by the GPs in this thesis), and those patients labelled as psychiatric (in the Dunedin survey), may not be equivalent. However, supervision as a method of teaching psychotherapy seems to have worked very well for these respondents, who report how confident they are in their counselling activities, how they are less and less worried by the “difficult” patient in general practice (with interpersonal difficulties), and how ongoing educational sessions with their supervisor is a rapid and effective method of learning.
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The other interesting point from the Dunedin survey was the wide variation in the reported rates of psychiatric problems across different practices. Per doctor, the range of patients with depression, for example, ranged from none to two hundred! This variation seemed to indicate variation in assessment, rather than in rates of disease across (presumably) similar populations. Were some GPs under-diagnosing depression, while others saw it at every turn? Clearly, there are inter-related questions here about assessment and competence in management. This research and the Dunedin survey indicate that GPs need both education and support in their management of the patient with psychiatric or counselling problems. This thesis indicates that supervision can provide another way of meeting those needs, apart from traditional CME.

6.10 Supervision as narrative story

This chapter has been laid out as a developing story, for it is only as a narrative within a particular context that the stories here have meaning. Both individually and collectively, it is a story of exploration, bringing in such qualities as courage (being different to one’s peers), perseverance (overcoming certain challenges), and self-revelation (becoming more aware of one’s strengths and limitations). As noted in Chapter 5, stories always involve paradox, where the characters attempt to resolve the tensions between various pairs of binary opposites (Macquarrie, 1944: Tillich, 1956). The relevant polarities here (amongst others) are rationality versus irrationality, the individual versus the community, and privacy versus self-disclosure. These will now be examined with respect to the narrative of supervision.

Polanyi posited that all knowledge is in fact, personal knowledge (Polanyi, 1958), being grounded in certain ways of knowing amidst a certain set of epistemological assumptions, most of which are usually taken for granted and not articulated explicitly. As part of the long history of western medicine, the doctors in this study have been enculturated into their role as GPs. Their training verged on an almost indoctrination into the principles of biomedicine (Sinclair, 1997) to the extent that few doctors can stand back and look at the underlying philosophy of medical practice in a dispassionate manner. In embarking on their explorative journeys into the worlds of mind-body medicine and of psychotherapy, these GPs became increasingly aware of
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the limitations of their received mode of practice from their training. So the first
tension or paradox that becomes apparent in their stories is rationality versus
irrationality; the tension between acting unconsciously, versus becoming more self-
critical and conscious of one’s motives and philosophies. Here, these GPs became
more aware of biomedical injunctions, the limitations of training, and the possibility
of going beyond that narrow (albeit useful) framework. That so few practitioners do
so (and that so many others appear content), could be an indication of how powerfully
conforming the medical training and professionalisation process is, and how difficult
it is to gain Polanyi’s “personal knowledge” about the basis of medical epistemology.

These ideas also indicate the tension between individuality and the community; in this
case, between the individual GP and the medical community. The section on barriers
to getting supervision included the cultural pressures of conformity, and most of these
GPs remain rather coy about their involvement with supervision. The paradox that
required resolution was how to individuate from the rest of their peers.

The third paradox in their stories is one of privacy versus self-disclosure. At a 1999
workshop on supervision in Dunedin, Tony Williams commented how revealing and
exposing it is to talk about one’s work. While this was not mentioned explicitly in his
book (Williams, 1995), he noted that supervision can be just as challenging (if not
more so) as psychotherapy, as one’s mode of practice is a carefully built selection of
roles, usually only revealed to the health consumer rather than to one’s peers. Further,
in psychotherapy there is a known purpose or goal, while supervision has the potential
to open up areas for examination that were previously unknown.

In medicine, there appears to be a considerable reluctance to be open about one’s
work, perhaps not surprising given the history of demeaning undergraduate
educational practices (confirmed by these respondents). Yet these GP have worked
through the tension of either being private about their work or discussing it openly.
As they also pointed out, they were seeking good feedback, but at the same time
wanted that to be done in a safe context. Deciding to put their previous experiences
(of being unsafe as a learner) behind them, and to place themselves in potentially
exposing situations, seemed to be an almost act of faith, grounded in a pressing and
urgent need, and with only uncertain outcomes ahead. The story of supervision then, involves some of the classic paradoxes outlined by Tillich.

6.11 The “good enough” doctor
Winnicot (1965) initiated the idea of the “good enough” mother, who “can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task” (page 49). As noted already in Chapter 2, this concept has been taken up as a model in a number of texts on supervision (Freeman, 1997; Hawkins and Shoet, 1989). The helping professional needs to be similarly held and supported in his or her task. As Freeman (1998) said; “one must receive nurture or support oneself to be able to offer it to others” (page 78).

The GPs here were deliberately entering into more intensive personal relationships with patients through their counselling and psychotherapeutic activities, and had chosen supervision as a framework to do so safely. The quotes listed so far demonstrate the “holding” capacity of the supervisors. They listened to the experiences of the GPs, they facilitated their learning as neophyte counsellors and perhaps most importantly, they validated the GPs in their activities and ideas that were sometimes at odds with the rest of their professional culture. Freeman (1998) listed the components of her model of “holistic mentoring” for GPs in the UK, which sounded very like the features identified here; “personal support, continuing education and professional development” (page 46). In medicine, continuing medical education (CME) is often done in isolation to the other two components, but in Freeman’s mentoring and in this study, the three components are clearly inter-related and necessary for each other to coexist.

Personal support and holding of the health professional in his/her role is a relatively underdeveloped concept in medical practice. De-facto support could occur by way of being a respected and accepted member of an established profession, but these GPs have found that to be a mixed bag. Similarly, section 3.23 on the culture of general practice on page 48 indicated the lack of professional support, which may be one of the reasons for the compensatory emergence of peer groups. As noted, the Lone Ranger style of practice is quite prevalent, and even in group practice, GPs struggle to
develop a sense of shared purpose or collegiality. "Holding" then, within the profession of medicine is relatively absent, and the sense of relief that these GPs shared from having supervision is perhaps testimony to its relative absence beforehand.

Winnicot had also developed the idea of the "environmental mother"; the good enough mother who provides a nurturing and holding environment, so the child can learn to trust and explore in its journeys away from the mother. A goal of this for the child (eventually) is to be able to be separated from the mother, but still feel held within its environment. In other words, maturation involves the capacity to be alone.

Taking this analogy back to the helping professions again, the professional culture could be seen now as the environmental mother. The discussion above indicates how poorly the GPs were supported in the general medical culture before they started supervision. No wonder then, that they found supervision so supportive.

There is a final twist in this discussion on the supervisors as the embodiment of the holding or environmental mother. In some of their early experiences of supervision, these GPs were not fully held, and were perhaps challenged too strongly. One interpretation could be that the supervisors were relatively naïve early on, being unaware of the lack of "cultural holding" in medicine, or the psychological fragility of doctors in general, or the importance of their own role in relation to their supervisees. Going back to Winnicot's original words on the enablement of the mother (see above, page 114), the supervisor needs to be aware of the "essential nature" of the mother's task. Part of the early collective work of these GPs may have been the education of those supervisors about the nature and culture of modern medicine, as leading the supervisors into roles that are now helpful for the GP community in general. In other words, supervision in general practice so far has been a mutual exploration between the supervisor and the general practitioner, working towards the notion of "the good enough doctor being held by the supervisor".

The role of the supervisor will be explored in detail again in Chapter 9, leading to a definition of supervision in general practice. Before that however, Chapter 7 outlines
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how supervision is helpful to heighten self-awareness of the GP which in turn facilitates career development, while Chapter 8 outlines the structure and function of a supervised practice.
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David: I think having supervision should increase your own sense of awareness about what you bring to a consultation, and the things in the consultation which you will naturally facilitate, and the things that you won’t, because of your own blocks, anxieties, defences, limitations.

Mark: And I see that as an important part of supervision... supervising me as a GP in the current climate, finding my way, and finding my future, I think that’s all professional stuff, and quite appropriate for supervision, so it’s not necessarily client-based. And again, a lot of it drifts into – what sort of person am I, what are my values...

This chapter of results deals with how supervision can promote professional development. Most of these supervisees started their supervision by focusing on patient issues, but as time went on and as trust developed in the supervisor-doctor relationship, other career issues became legitimate grounds for discussion. Here, the focus of supervision was almost entirely on the self of the doctor by increasing his/her self-awareness. This is in both minute-to-minute issues at work, as well as by explicitly focusing on career choices and issues. The sections in this chapter are challenge with safety, the effect on self-awareness, career development, the wounded healer and becoming a supervisor themselves.

7.1 Challenge with safety

These GPs wanted to be challenged and criticised in a safe environment in order to grow and develop in their professional role. Mark for example, came up with this idea in response to a very open-ended question.

Is there anything else you want to tell me about the process of supervision? Any other topic you’ve been thinking about?

Mark: Um, [pause], I must say how much I enjoy it. It’s in my nature to want to be criticised. But like anyone else, if I’m criticised, I want to be criticised safely, and gently, rather than put down. But unless I get criticism, I can’t grow. And, [pause], so it’s a wonderful opportunity for someone to put a spotlight on me, and be safe about it. So, you’re an avid learner, I take it. Yeah. Even though I find learning difficult.

By contrast, Paul talked about the ongoing “dissonance” that he felt at work. To resolve this he wanted someone to “throw it back at him”....
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Right, and one way of resolving that dissonance is to reflect on it?
F/Paul: Yes, reflect and you know, talk about it, and that's where I find that supervision is a place where you can throw that around without.... Cause sometimes it's quite threatening to your colleagues if you actually, you know, say the whole thing's crazy, it's not going to work, or that it's.... I mean you need a forum where you can.... A place where you can actually say these things and actually get someone to throw it back at you and reflect on it, you know what I mean?

The concept of wanting to learn by being challenged is a liberating change from much of the undergraduate culture, where roles such as “The Reluctant Learner” and the “Didactic Teacher” are not uncommon in medical school.

7.2 Effect on self-awareness

Supervision helped these GPs become more self-aware of their own feelings, ideas and personal issues, and how those can impact on their work with patients. Wendy for example was more aware of how the “space” she is in impacts on her perception of her patients.

I've [pause] become a lot less blaming with patients. Um, I see their problem's much more to do with the relationship, or to do with the way they relate — rather than, ‘this person's a pain in the ass and I don’t like them’. Um, there are a few of my patients that I don't like, and the ‘heart-sink’ is usually a reflection of the space that I'm in, rather than the relationship I have with that patient. That if I'm really tired, and pre-menstrual, or my life’s going badly, I still get that ‘oh my god, not Mrs So-and-so, I really don't need that today’.

But, I [pause] am much less inclined to feel that, I feel more capable and aware of what's going on, when I'm with some of those people. It used to really wind me up.

She said this change was because she had worked through all those “heart-sink” patients with her supervisor.

For the last six months I was in supervision, I was really scratching around to think who could I present. Because I felt so much more on top of things.

You had less heart-sink patients?
Yeah; Or they’re the same old patients and I'd already presented them before, and felt that I'd worked through the issues, but most stable practices have a collection of these people who are more challenging, and I suppose I've talked about all the ones that really got up my nose, or pushed my buttons, or stressed me, or worried me.
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And all the new ones who came along, reminded me, or slotted into my understanding, about the ones that I already knew.

These GPs have worked through the issues about so many "difficult" patients that they can more readily tackle the problems of new situations. I also asked these GPs about the effect of having had personal psychotherapy, as another method of increasing self-awareness. It turned out that such self-awareness was an important way of increasing tolerance of patients, who were less likely to "shake my cage."

Does having had personal psychotherapy influence how you are as a doctor?
No question; no doubt about that, that being self-aware, and having worked through some of my own issues... looking at what I knew about the things that triggered me into fear, or anger, or anxiety...
And, how different a lot of that is now, and it's always an on-going journey. I think I have much greater integrity as a doctor, because I know where I stop, and the other person starts, and what shakes my cage – where I might over-identify with someone, or have a negative response to someone...although I still get really ticked off with people who are majorly lost to being martyrs and doormats and blamers...
That at least I have some understanding of where that aversion comes from.
About aspects of myself. And I don't tend to dump it all back on the patient, and say 'well, I don't like you, and this is your problem' and so I'm more tolerant, and I'm less eagerly triggered into my own stuff.

This took some time to develop, however.

My perception is, that you worked actually quite hard to improve your skills as a GP over the years, (or) do you think those improvements in critical faculty - or whatever it is - is just through time?
I guess I don't recall consciously trying to learn it, or trying to make it happen - but it's been something that has increased as time's gone on.
And supervision has - not so much - taught me what to do, but it has shown me what I'm doing, and allowed me to be more aware of what I'm doing, and to turn up the volume of the critical bit's. But, it was already there in some form.

David also noted how he had become more aware of himself.

So you've become interpersonally aware, is that right?
Absolutely, I think that's the other thing about the counselling and psychotherapy, for me it has also very much been a personal journey, and my awareness of the issues of my patients increases my awareness of myself.
And I'm totally convinced about the... if you're going to do counselling or psychotherapy, you need to have some yourself, and having done that, my own
level of self-awareness is much greater, and my ability to be aware of my patients is also much greater.

He differentiated however, between the supervision-induced personal awareness, and the purpose of personal psychotherapy.

I think having supervision should increase your own sense of awareness about what you bring to a consultation, and the things in the consultation which you can facilitate, or that you will naturally facilitate, and the things that you won't, because of your own blocks, anxieties, defences, limitations. So, supervision certainly should focus on what the doctor is bringing to a consultation, but, so if that means to some degree that's psychotherapy... and in a limited way it is, but personally, I haven't found supervision to be... you know, I wouldn't call supervision psychotherapy. Supervision can highlight areas I need to deal with in myself, but doesn't spend time on those areas. I would need to sort it out myself or seek specific psychotherapy for them.

Supervision also increased one doctor's awareness of difficulties with specific patients.

(Supervision) has caused me to examine myself and my anxieties and tensions in different situations with my patients... prior to going into supervision, I was starting to note my anxieties with patients, and what it told me about myself. And I found, giving that some thought, that I resolved a few things, a few issues.

One was an issue I had with my mother, that middle-aged female patients were generating with me. Another, was an issue with my uncle that, large men in dark blue business suits, who, businessmen of one sort or another were generating in me, which was a relationship issue with my uncle. So, I'd started to notice some of those things, but supervision definitely carried that on a lot further, and I'm much more aware about what happens in a consultation, and what it generates in me, and use that as a prod to explore my own issues and to get my crap out of the way, so that I'm actually free to relate to this person.

Supervision here has increased this doctor's awareness of certain types of patients who were deemed to be "difficult". The difficult patient is only difficult to that particular doctor, as while other doctors in the same situation could also find that same patient to be problematic, the degree or type of difficulty is always doctor-dependent. Blaming the patient for being difficult is usually a short-term and shortsighted way of avoiding a more self-orientated examination of the issues for the
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doctor. These respondents have very ably demonstrated how self-awareness alters their perception of the “difficult” patient, and concepts such as the “hateful” patient (Groves, 1981) are shown to be unfortunate and naive.

Wendy used her supervisor to work issues from her medical family background. This understanding helped her realise how patients’ needs were more often placed before her own.

Um, [pause] just that idea that – I guess I was brought up with a very strong sense of duty, and that good doctors were really self-sacrificing – my father and my grandfather were both GPs, and my experience of both of them as a child, is that they were hardly ever bloody well there, because they were out looking after patients, because that’s what you did when you were a doctor. Um, so I feel like I was imbued at an early age with this odd notion that patients’ rights were paramount, patients’ needs came before my own, and that if I was being ‘selfish’ in looking after myself, then I wasn’t being a good doctor.

If nothing else, supervision has helped me to come to terms with the idea that that’s not a healthy way of functioning – for me, or for anyone really, and it isn’t even very helpful for the patient, ’cause if I’m not modelling a healthy way of life, and having a functional life for myself, then I can’t be present with the patient, and I can’t be congruent in what I’m trying to help them to become.

Similarly, John came to some realisations about his family background that had drawn him into medicine.

Oh, I mean my father, his father died when he was 12. He was the eldest son of a family of four and they struggled trying to keep the family. He got a scholarship (to study) and he was the supreme rationalist. Dad was a member of the (political) party and I inherited his need to solve the world’s problems.

One of these GPs used supervision to review his “guilt” feelings about needing to work so hard in the church, on top of his work as a GP. As an elder in the church, there was pressure on him to “spread the good word”, or to go door-knocking in the name of the church and so on.

For a busy GP, getting home at night ...with feelings that somebody had walked through his head, you know, that sort of feeling? This is crazy stuff. There’s no way I can... I’m already involved, cause I have this different concept of how one does the work of the church, and that’s got something to do with relating to people.

Tell us about that?
If you expressed it in... if you help someone, I mean, you're doing the work of, if you're going to look at the gospel stories and the story of Christ and sort of thing, you're doing that work. Whether you're doing it officially in the name of the church, or whether you're just doing it because...

**Just being there..**
Yeah that's right. They are both exactly the same, for goodness sake.
In my mind, there's no difference...
But I feel, I get quite a buzz out of doing something like that. But as for going out door knocking, it just gets. So I'm out of there like a rocket now, I don't feel bad about it.

The outcome of supervision here was that he no longer felt guilty about resisting pressures from the church. This awareness arose from extended work in supervision on how to juggle his work with this other commitment. Being conscious of those pressures enabled him to make more realistic decisions.

It seemed that these doctors were more psychologically aware than others, (at least in their perception). I had often asked about this specifically.

**So would it be fair to say that the you're reasonably psychologically aware, and psychologically accessible, which helps you to facilitate patients, if you're psychologically aware.**
And be emotionally accessible to them, where that's appropriate, within appropriate bounds.
**You come across as being quite solid in your profession if you can stand solidly with patients who are emotionally volatile, and compared with your colleagues who are emotionally unaware, or, psychologically unaware. Is that fair to say?**
I think that's fair to say, the emotional situations with my patients quite often have my heart beating quicker than it usually beats, and I'm on the edge, and I'm stretched and challenged by it.
But, I feel like I get through those situations better, increasingly, and with more comfort and with more sense of – it is okay for me to just be who I am in those situations, that I don't have to fulfil some artificial role.
That I can actually be myself, which enables me to relax much more. I think that's true to say.

To be able to relax in the tricky situation of the emotionally demanding patient would be a good outcome of supervision. Another aspect of self-awareness is admitting that one is vulnerable. John was particularly strong on this, talking generally about the medical profession.
I feel, I actually feel really strongly that as a profession we stuff up by not admitting that we are all absolutely vulnerable and we all have things that happen that are horrible and that we don’t talk about it and we all minimise, ignore and deny.

I feel passionately about that, really pissed off with the doctors after (a death of a patient), it was really interesting how many people whenever I told them the story, they overly said ‘well anyone else would have done the same, there’s nothing wrong with you’.

They had a need to, you know the responses are either absolute dump, ‘oh, you killed that baby’ or ‘it was none of your fault’. There was no exploration and a fear of opening anything up around the profession which I think is whacked.

The admission of vulnerability in medicine (or its omission) will be discussed further at the end of this chapter.

7.3 Wounded healer

As a further development of self-awareness, some of these GPs also believed that they deal with the suffering of others better, if they have a sense of their own suffering or woundedness (Breward, 1995). The idea that GPs facilitate healing of their patients will be posited in the next chapter; here the focus is more on the doctor’s woundedness as being a contributing factor to this.

Do you have to be wounded to be a healer?

I think you definitely do, and I saw myself, pretty much, as relatively ‘unwounded’... but discovering actually, that I am wounded.

And getting a feel for that, and an understanding of it, is a great resource, in terms of being able to empathise and get a feel for, understand, other peoples’ ‘woundedness’.

If the doctor hasn’t got a reasonable sense of his or her own woundedness, then the doctor’s capacity to deal with the patient’s woundedness and suffering, is limited in direct proportion to their understanding of their own woundedness.

So that... mutuality contributes to their recovery, or their healing?

I think it does. It’s my humanity, interacting with the patient’s humanity, and the more authentic and human I can be, and the more comfortable I am with that, and the more I can stop my own emotional issues getting in the way of my interaction with that patient, the more open I can be to them as a human being.

And I take the view that a healthy human to human, interpersonal interaction is therapeutic, is healthy, is part of healing for the patient. It increases their trust in me as their doctor, my ability to cope with what they might dish out to me, which I think makes them more secure.
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Here, the emphasis was on the doctor as healer, but only insofar as the doctor is comfortable with his/her own emotional issues. "Healing" is not mentioned in most textbooks of medicine, nor is the word in common usage in medical circles. I have been involved in medicine in some way or another for almost three decades, but very rarely have I heard practitioners speak so frankly about their work and their goals with such degree of open disclosure.

7.4 Career development

These GPs also use their supervisor as a sounding board to discuss their career and professional development. Robyn gave an overview of this role of the supervisor.

So the supervisor's role there, is sort of, taking an overview of the practice, and the professionalism in it.
You were actually talking about global view of the practice, and I was going to say that one of the things that actually has been coming up recently — that we’ve discussed recently, a number of times — is my practice, as I am aware of my practice changing, and my view of general practice changing. Supervision has been another sounding board for me, to be able to talk about both my changing attitudes to general practice...

Mark confirmed that he also used his (new) supervisor in a similar way.

I've only actually had five sessions with him, something like that, and in quite a lot of them we've actually got into discussing professional issues which weren't necessarily client based. And I see that as an important part of supervision, I mean, supervising me as a GP in the current climate, and all the rest of it, and finding my way, and finding my future, I think that's all professional stuff, and quite appropriate for supervision, so it's not necessarily client based. And again, a lot of it drifts into — what sort of person am I, what are my values...

Robyn touched on the concept that "in telling the story, she then understands it herself". This arose from another open-ended question, and she started with the idea that she used the supervisor to talk over any change she was considering making in her practice.

Do you think that in supervision has made a difference in your life? (Long pause) Yeah, supervision's made a, yeah, it certainly has. I mean, in lots of ways, I don't think I would have developed that, sort of, global concept of respect as clearly as I have now, if I hadn't been through that process.
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When I've been off and learnt something new, that I've decided to incorporate back into my practice, one of the people that I talk that over with, is my supervisor.

I don't just talk about clients, I talk about how I practice, my general practice. So, if I've made some change, or discovery, or whatever, I bring that back - I take that to supervision, I say 'I went to that conference and I learnt all about this stuff, and I'm going to put it into my practice, and this is how I'm going to do it'.

So, most - more a broader thing there, isn't it? Your profession.

It's like a professional sounding board, and I wouldn't do that with my peers - my general peers, in the same way. I mean, some of my good friends, who are peers, I might come back and tell them about that, but when I discuss it with my supervisor, it's in a much more global sort of way, and I'm much clearer about it, because I have to tell the story.

And in telling the story, I have to put all the things in their little slots, and, so that he understands the story. But then, I understand the story as well, 'cause in the telling of the story, I sort of, tidy up all the details.

This aspect of supervision (that in telling the story it becomes clearer to the teller as well) is one of the strengths of supervision as a method of reflective learning.

Lee used different supervisors at different stages in her career for specific professional development.

Sort of like professional development, isn’t it?

Yeah, and then, that’s right, career development. With (one supervisor) I’d say 90% was clients and 10% was professional development; and with (the next supervisor), I’d say 70%-30%; and then with (my third supervisor) it’s been, sort of 90% dealing with other professional development, sort of, only 10% clients...

...You must have been having less oversight for your cases.

Mmm, but I s’pose I did talk about cases intermittently, but I felt like I was going along fine, I had a good – there didn’t seem to be a great need, there seemed more need to do this other stuff.

Like both David and Wendy in previous sections, Lee had become more comfortable with “normal” patients and so used supervision more for other development.

There wasn’t a great need (to talk about cases) because of what?

I was more confident, and I felt alright about the work I was doing. I didn’t have any major difficulties...I was focusing more on the group work...

So in an overview then, you’d use supervision to take you to the next level of your career development; firstly to outline cases with clients, then there’s development of group work. And each time you’d used a specific supervisor to build you to that next level. Is that a fair summary?
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Yeah, I suppose so. I mean, it was mostly clients with (the first one), and then more clients with (the second one), but I suppose it did open up into professional development. And then, because I was doing (other) training in parallel really, then that became the next need for me, the next logical step. It wasn't because of any difficulty with the supervisor.

Do you think you could've done those career steps, developmental steps without having a person to talk those issues over with?

Um, [pause]. No, but supervision definitely helped.

One of the GPs used supervision to review her decision to sell her practice. This related to her growing understanding that counselling within the 15-minutes was actually very difficult.

I feel like my first step is to sell the practice. I can't really plan too far ahead. Don't you dare ask me why I'm selling my practice. [pause]

In fact, supervision is one of the reasons that I'm selling my practice, 'cause I've decided that psychotherapy in fifteen minute bites, is incredibly dysfunctional, and a stupid way of doing things, 'cause it's too hard. I can't be bothered with it anymore. I'll either do it properly, or not at all. But that cuts at the fundamental heart of general practice, and its validity.

Paul noticed in retrospect that when he didn't have supervision, he had made some career choices that could have been different, had he had supervision.

So, in some ways you're saying that if you had the supervision, and before you made the decision to go to (overseas), you would have been, perhaps would have had a more effective style of looking at those issues, and you may not have made a decision.

That's possible, yes.

So, if you can extrapolate to the purpose of the function of supervision then it would be to ah, incorporate or introduce reflection into your style or practice.

Absolutely, yes, mm, mm.

Another of these GPs used the supervisor for help in writing an article on certain aspects of practice. Because he had already talked those situations over with the supervisor, her input was very helpful.

That was a flash of light, brilliant when she started talking about that to me, because I was sort of all caught up on...the patient.

One GP had also used supervision to deal with the image of GPs in society.
Yeah, definitely. There is no doubt, that patients’ expectations of what doctors will do has increased at the same time that, patients’ reverence for doctors as a high-status member of society, and someone who shouldn’t be questioned etc., has gone down. That doctors are now to blame for lots of things. They’re often criticised and not trusted, but at the same time, we’re expected to do more and more, and then make mistakes, that tension seems to me to be increasing. That must affect all doctors, as far as I can see.

This sounds similar to Freeman’s summary of the pressures on GPs in the UK after the health reforms of the 1980s, where there was “increased accountability with decreased professional autonomy” (Freeman, 1998). Having such societal pressure on the health professional and not having a forum to discuss it, would in theory at least, be a major source of stress. Some studies have confirmed that the perception of “being blamed” in the health professional’s role is indeed a significant source of stress (Dunst et al, 1988), but there is little reference in the literature to methods of dealing with that particular stress. Supervision, at least as defined and experienced by these doctors, would seem to be an ideal forum to explicate and cope with those pressures.

John’s commitment to supervision was evident in this quote, and it illustrates the ongoing nature of supervision as an integral part of professional development and of the supervised practice.

"I think there are several elements to it, there is keeping yourself honest; 'mother confessor' you know. This week I had my supervision booked for Wednesday morning and because we were a doctor short I had to work Wednesday morning. The easy thing to do would have been to cancel the session. I moved it to the next day, even though it was hard to get there because of the discipline of knowing that if I cancelled it then I was not being kept honest and I was not, it's a place where I know that I will say the things that are on my mind and be open to someone saying, 'well that's crap, think that over, you're choosing to be grumpy, you're choosing'. You know, sort of challenging my way of seeing things. This week has been horribly stressful, all of that I knew I was stressed, but going and listing why and what I was doing about them all, I see as being a useful discipline. So as not to end up burning in a unconstructive way when there are things I could have done to avoid the burning, if you like."
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7.5 Becoming a supervisor themselves

One of the GPs in this research was taking a mentor role with junior doctors in his practice.

John: I would see myself as their mentor, I'm not sure what being a mentor and a supervisor is. I guess I would have liked it when I first started in practice. That feeling of some support, that you're not sure, you're scared of making mistakes, lots of little things happen everyday and in fact most of it has been really interesting, most of it is just to do with confidence, it's got nothing to do with competence at all. The number of times when any of them have brought anything to me where I actually felt they had done anything wrong is absolutely minute. By and large they're not sure what to do, so they did this and they did that and that's fine, I might have done this a little bit differently. In terms of the clinical case discussion stuff and yeah there are some things that I can add in, in terms of greater experience of saying, well I've done that in the past and it didn't work and I tried this and this.

However, while all the other GPs had extensive experience themselves of being supervised, they seemed less ready to supervise others. In the interviews I challenged some of them about this, feeling that they had all the skills and knowledge required for this next step. Despite their intense involvement with patients (and clients as part of their psychotherapy practice), none acted as formal supervisors for other doctors. Some did however, lead various training courses for GPs. In doing so, it is likely that they use all their experience of being supervised, having internalised many of the roles of the supervisor. At times in the interviews, we also discussed the wider promulgation of supervision throughout the GP community. These GPs would be ideally placed to offer supervision to their colleagues, perhaps being more knowledgeable about general practice than the psychotherapist supervisor, and perhaps less psychologically threatening than the psychiatrist.

Mark: That's why I think, that -- as you said before -- maybe supervision becomes a much more widely developed thing and the likes of you and I, might be in a very good position to provide supervision at the level that GP colleagues would want it -- rather than from the purity of classical psychotherapy.

That would be quite a step though. From undergraduate training to work in practice, there are few examples of facilitative mentoring, as Mark noted in his undergraduate experience.
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Well, I remember my supervision (as an undergraduate); I was given a physiology lecturer’s name, ‘he’s your supervisor’ or whatever it is, ‘go along and introduce yourself to him’. So I went along, and he said ‘oh, yeah, I said I wasn’t going to do it this year, they’ll give you another one, bye now’. So I went along to the other guy I was given, who said, ‘oh, ah, I’m your supervisor, everything all right?’ and I said ‘yep, fine’. He looked more frightened than I was. That was the end of supervision for my medical school. You grimace, but it’s true, we actually found our own mentors, by various tutors, lecturers, whoever we felt we could relate to, and could talk to us.

One of the GPs in the focus group raised the idea that because she felt a little different to her peers, it may not be appropriate to be supervising others.

What are the barriers to (us) being mentors? And for me... the barrier is that... I feel, I feel not in step with many of my peers, okay, and I feel okay about that...I practice medicine in a different way to a lot of my peers. And so that for me, that’s a huge barrier to becoming a mentor because if someone comes to me for mentoring, I think, I think about medicine in a very different way to a lot of other doctors. So therefore, they don’t know what they’re getting themselves into it. I don’t think that’s fair to them. I think they’d find that quite quickly, wouldn’t they? (Loud laughter) Yeah, but you know what I mean. And listening to like everybody else on board who has basically said that they think that they practice quite differently to a lot of their peers, it seems to me that that’s.... if I’m in the mainstream, should I be offering advice to the mainstream?

My own feeling is that this reservation is unwarranted. These GPs have demonstrated their ability to respect and honour their patients and to not force their own solutions onto them; I am sure this would be the same for any supervisees who came to them for supervision. The main barrier, I suspect, is simply a feeling of newness or even inadequacy in this different role. Given that they have surmounted the other barriers in these interpersonal relationships, it would be surprising if this barrier proved too large.

Paul felt that to be a supervisor for a colleague, they should not be in the same practice, echoing previous comments on “functional difference”.

I’ve got a comment here.... We know them too well in the sense that I think if you were going to supervise...you should be supervising people who are not in your practice, which is one thing. And they should be (from) somewhere else in coming, rather than.... I guess more distant colleagues than close colleagues if you know what I mean?
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The final point on this at the focus group was the need to have supervision yourself if you were supervising others. All agreed that this would be almost mandatory.

_F/Mark_: Well you'd need to be in supervision yourself if you're going to be supervising others.
_Paul_: Absolutely.
_Mark_: It implies a psychotherapeutic base to your life.

7.6 Discussion

This chapter has outlined how these GPs wished to be challenged about their work, and that continued challenge in a safe environment had major effects on self-awareness. Similarly, the supervisor was used as a sounding board to discuss career development. They demonstrated how significant changes in their careers could helpfully reviewed by the supervisor in a type of mentor capacity, and many of them were taking influential roles now in medical education. It is likely that they will form the basis of a cadre of GP supervisors over the next decade, which will be able to mentor other general practitioners about their work. These GPs were self-directed supervisees, starting supervision entirely from their own volition. They continue to use it as an integrated part of their professionalism. This is in contrast to the mentoring scheme in the UK (Freeman, 1998), where external funding was used, and for only a limited length of time. That scheme did however, initiate considerable debate about the place of mentoring and the role of the mentor in general practice, and Freeman has made a significant contribution to the literature on these issues. In the New Zealand context, such awareness is in its infancy, although this research adds to the preliminary work from Parkinson (1998).

This chapter also initiated a conceptual framework about healing through the therapeutic relationship. By being held within the supervisory relationship, and by judicious use of subjectivity and awareness of their own "woundedness", these GPs were able to define themselves as healers. This self-definition has been absent from medical discourse for several hundred years, but it links with the main purpose or goal of being a health professional; the relief of suffering. Despite Cassell (1991) reintroducing this concept in this decade, medical outcomes are rarely thought of in
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this way. Through their commitment to professional development and to an ever-increasing self-awareness, these GPs are perhaps embodying a modern concept of health professional as healer.

7.7 Reflective learning

Supervision appears to be an excellent example of reflective learning, using all the stages of Kolb's (1984) learning cycle. These stages were outlined on page 12 of this thesis, and the practitioners here seemed adept at taking their experiences of practice to their supervisors to review in considerable detail. From this, they were able to generate complex concepts about their practice and their roles, and were able to incorporate those ideas when back at the coalface of practice. The links between experience, to philosophy, to experience again, are mentioned in detail throughout the chapters of results, and while these practitioners may not have been consciously aware that they were embodying Kolb's theories of learning, the match here between theory and practice would suggest that Kolb's ideas were quite accurate.

According to theory, it is the divergers who have strengths in concrete experience and reflective observation (Smith and Kolb, 1985). These learners would take naturally to supervision, which would use their dominant learning style to maximum advantage. However, I am unaware of the learning preferences of the GPs in this study, and so cannot make any links between their enjoyment of supervision and their preferred method of learning. Divergers are however, suited to counselling or organisational development. It is tempting to speculate that in distinction to the majority of their colleagues (assimilators or convergers, for example), these GPs were drawn to psychotherapy training as a function of their learning type. This line of reasoning also suggests that it would be unwise to recommend that all doctors use a more reflective practice, as many would be uncomfortable with that style of learning.

However, Kolb was quite clear that effective learning depends on using all stages of the cycle, that staying in one phase is ultimately unhelpful in learning, and that focusing on one's under-developed phases of the learning cycle will give more flexibility. The GPs here explicitly outlined how they moved from experience, to philosophy, to experience again, and that they had to learn to do so. It seems unlikely
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that these GPs were all divergers to start with, and more likely that they learned the art of reflective practice as part of their supervisory experience. In other words, they demonstrated that they could learn new learning styles.

Compared to traditional teaching and learning processes in medicine, supervision seems to be based on a quite different premise. Firstly in medicine, there is a heavy emphasis on the content of learning. Undergraduate students for example, still ingest a huge number of facts about the body, predominantly from lectures. In later years in ward rounds for example, teaching is still about the patient and his or her disease. Secondly in medicine, the discussion about the process of learning has been relatively absent. The instillation of facts into the dependent learner is the predominant style of teaching, without necessarily changing this to more learner-centred methods as the students mature into young doctors (Grow, 1991). The outcome of this is that medical graduates are inculcated into passive learning, they remain unable to set their own learning agendas, and continue to be uncomfortable when asked to become self-directed (Bould and Walker, 1998; Wilson, 1995).

The difference with supervision as a method of learning as (outlined in this thesis) could be hardly more marked. As Robyn said; “I set the agenda”, a comment that was echoed by all the other respondents. This may be one reason why supervision has so far been relatively uncommon. Continuing medical education (CME) for example, has topics that are usually set by the CME coordinator with an “expert” resource person, often requiring no more of the attendees than simple attendance. In contrast, setting one’s own learning needs (for example, learning how to do counselling or psychotherapy) requires considerable volition and energy. Supervision requires the supervisee to be more self-directed than is customary in much of medical education, and so it is not surprising that so few take it up.

There is considerable resistance generally from doctors and medical students however, when they are asked to formally reflect on their experiences. I can say this from personal teaching experience, having requested both undergraduate and postgraduate students in 1999 to write structured accounts of their work in a journal. Some did so readily, and found it helpful; some did so quite unwillingly, but also
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found it helpful, while others were simply unable to journal at all. Perhaps any recommendations about compulsory supervision would have the same outcomes. Perhaps the key to selling these ideas would be through learning style preferences, as well as through adequate theoretical explanations. Learning styles may be an important key to the understanding of supervision and to “selling” the concept to students.

7.8 Supervision as learning about process

In medicine generally, the learning is about other people or patients. In supervision, the learning is not only about others’ needs, but also the learner is effectively in the patient’s position, as part of the supervisor-supervisee relationship (as will be discussed in the next chapter). As Mark said (page 159); “In supervision, I am experiencing something which my patients experience in therapy with me”. The difference between traditional medical teaching (about the patient), and supervision (where the learner can experience what it is like to be a patient) is deliberately polarised in Figure 7.1 (next page). Medical students can only experience the role of the patient, when they themselves become ill and seek medical help. Yet the emerging genre of pathographies (where doctors gives testimony about their own illness) illustrates how powerfully they are affected by being in the patient’s role, and how that changes their philosophy of practice. However, medical training employs very little role-reversal with the patient, with doctors preferring to stay in the role of observer (moves to increase empathy as part of patient-centred medicine, notwithstanding).
From my own teaching experience, I have noticed that medical students are reluctant to role-play with each other (for example, one being the doctor and one being the patient (Wilson, 1999a), preferring instead to use professional actors as simulated patients.

By contrast then, learning in supervision is an embodied experience. The section on parallel process in the next chapter (page 158) will make this explicit; the supervisory experience is a process that can model how the doctor can be for his/her own patients, as the supervisee can experience it first hand. This is not only through parallel process; it is also through deliberate role plays with the supervisee acting as the patient. The result of these activities and processes is that through being supported and respected, the supervisee learns to support and respect the patient. By being trusted to work through issues at his/her own pace, the supervisee learns to trust
patients to work through issues at their own pace, and so on. The medical student in traditional teaching can emulate the styles of doctoring that they observe (and there is no doubt that this is a powerful teaching method), but it remains an objective experience. In supervision, the subjective experience is also included, and these GPs have indicated just how quickly they learn and how enjoyable the process is.

These considerations seem to stem from the qualities of the supervisor-supervisee relationship. Once again, there is a contrast between traditional medical teaching and supervision. In the former, students have a large number of transitory and superficial relationships with teachers, characterised by a focus on other peoples’ problems, to the exclusion of almost any focus on the self of the learner. In supervision, the teaching relationship is based on an ongoing, in-depth relationship, which legitimately includes areas of overlap between professional and personal. Again, here is another barrier to supervision; the cultural shift from shallow relationships to more intense and personal ones.

The next chapter illustrates the content and process of a supervised practice, including practical examples of these relationships considered above.
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David: Life's richer than that. Life is essentially about relationships and in medicine, interpersonal connection and communication, your life and everything that you are connecting in some way, at some level, with this person and their life and everything that they are. And, so I want my supervision actually, to be like that too, it's got to be interpersonal, not just mechanistic.

This chapter observes how these GPs actually ran their practices, and how they incorporated their supervisors into their work. It is my contention that a supervised practice embodies values and philosophies that are significantly different to more traditional general practice. An illustration of this difference was one of the features of the educational group on mentoring noted in Chapter 3 (page 49). The group became rather bogged down with the last topic on the list of learning needs; “can you measure the outcomes of doing mentoring?” The resource person was reluctant to answer this question directly, saying it was a difficult question and that she preferred instead to focus on her professional values, which were “for mentees to say in touch with their purpose, monitoring of standards, and prevention of burnout”. This explanation appeared to be rather unsatisfactory to some participants at the time.

My interpretation of that situation was that it was one of paradigmatic incommensurability (Kuhn, 1997). The resource person came from a culture and philosophy of practice that was, to put it simplistically, “non-scientific”, in which words such as “measurement”, “outcome”, “trial” and “generalisation” were not so appropriate. The culture she was attempting to portray was more concerned with particular values, such as respect, personal ethics, being in touch with purpose, self-reflection, monitoring of standards and so on. On the other hand, the GPs at that session had legitimate questions (at least from a traditional scientific rationality) about the validity of an activity that was being presented to them.

As is typical of paradigmatic clashes, resolution was not possible at the time. In general, such debates may unhelpfully compare the strengths of one of the cultures with the weaknesses of the other, while the underlying assumptions of each are not discussed explicitly. Practitioners may be unaware of their underlying
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epistemological assumptions, having taken them for granted throughout their working life. These factors may have contributed to the course of that particular educational session, with issues that remained unresolved in terms of a fuller understanding of how the professionalism of mentoring/supervision is alike or different to normal general practice.

From the evidence in this thesis, and from the practical experience listed above in the educational group, there is a major paradigm divide between the culture of general practice and that of the supervision/mentoring community. This has a number of implications. It may be helpful for the reader to view various topics in this chapter as examples of different modes of practice in a different culture, based on different philosophical assumptions. This chapter will firstly describe how these GPs set up their practices, and then illustrate how they approached both the physically- and the psychologically-orientated patient. This leads to a consideration of the importance of the relationships between doctor and patient, and between doctor and supervisor. A supervised practice also implies that these GPs use their supervisor as a forum for reflection on their work, their roles and the boundaries around those roles. Lastly, there is some consideration of the role of the GP as a “healer” in the community.

8.1 The set-up in practice

There was considerable variation in how these GPs set up their practice to reflect their counselling and consulting interests. Some incorporated counselling skills into the normal 15-minute consultation, while others had hour-long appointments and some had separate rooms to do their psychotherapy. Wendy and Paul incorporated counselling skills into the normal consultation.

You didn’t though (have a separate counselling room)?

Wendy: I never have. By the time...I’d been working with (my supervisor) for a year, I felt quite confident that I’d have no trouble holding a one-hour counselling session. I had both the skills and the confidence to do it, but I no longer had the time; doing one hour long counselling sessions was just going to be too stressful on the practice load, ‘cause I was fully booked every time I was there... so I kept thinking, ‘maybe I will, maybe I will’, but I never got around to it.
Paul differentiated between certain types of consultation where micro-counselling skills were required within the consultation, rather than having formal counselling sessions. Sometimes he saw referred patients for assessment of depression, for example, and these required a half-hour session.

*But, you might be into saying, ‘well we’ll see you in two or three weeks and I want you to come back if bla, bla, bla’. And this is just to make sure your Prozac, check on your Prozac, bla, bla, bla. But there’s a sense of establishing a relationship.*

At other times he initiated interventions within the 15-minutes.

*In the ordinary consult, you sometimes, you just realise after you might have looked down the throat, that this is all to do with doing all-nighters...They’ve been spending 50 or 60 bucks a week on alcohol, that’s all totally, ah, chaos. And if you like, you just get into a different sort of mode, and you start talking about those things... You need to say to them, “okay man, well look I think we need to check your liver and I’m taking you seriously. You know, you’re not feeling well, I’m taking you seriously, but I reckon it’s probably the alcohol. Now, I would like to see you in a week. Do you think you could get these bloods done? Now what are you going to do to look after yourself between now and next week?”*

The other doctors in this study had more formalised counselling sessions with defined patients. To help differentiate these patients from ordinary ones, they were sometimes referred to as clients. Mark for example, had four-tenths funding through a local IPA as a counselling subsidy.

*Are you still doing psychotherapy with patients, I mean, formalised sessions?*

*Mark: Oh yes, increasingly, and in fact, I’ve moved (to) seeing patients or couples (in) a series of sessions, which might be the sixth attempt to work through a process for them. I’ve got one or two, I’d have to call them clients now, because they’ve moved away from being patients, who I’ve been seeing for a very long time. And, [pause], who are really looking at themselves and their processes, and that’s much more of a long-term relationship aspect to psychotherapy, and it’s a very nice balance for me...*

Robyn had a separate room for counselling entirely. This developed out of some realisations about how a different approach was required in counselling, compared to “ordinary” general practice.
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It took me years to accept that with difficult patients, I couldn’t actually wear both hats, as a GP and a psychotherapist. It took me several years to accept that I had to move some of my general practice patients over to a different general practitioner when I worked with them in psychotherapy. So, if you’re taking someone on for psychotherapy, you may have to say you can’t be the GP as well.

Robyn: Most of the time I’m able to change the role adequately, and I actually have different rooms, which helps. I have a different room for the psychotherapy, compared to my consulting room, which actually helps with the change. I’m different people in the different rooms.

This is an important concept (that the approach to psychotherapy is different to what is required in ordinary practice) and this will be explored in detail in the following sections.

Whether or not these GPs used one-hour sessions and/or a different room, they were exhibiting the concept of a supervised practice. They worked within the supervisory umbrella, even if they did not discuss all their patients with the supervisor. By discussing some patients in considerable detail, they incorporated the idea of their supervisor being “on their shoulder”, and so could draw on previous supervisory sessions and experiences in their day-to-day work. This differentiated their mode of work from other GPs, where clinical back-up only occurs indirectly in referral letters or in conversations with specialists. Furthermore, there is little focus in this latter form of supervision on the self of the GP, or on their relationships with patients.

8.2 Addressing both the physical and psychological aspects of general practice

These GPs wanted to work with “whatever the patient brings”. It seems that by having supervision for the counselling side of their practice, they gained more confidence with ordinary patients as they could recognise and deal with emotional factors in all consultations. With the emphasis in biomedicine being on physical complaints, the skill of being able to address both aspects of patients’ presentations is relatively new. David encapsulated several hundred years of medical dualism when he talked about most doctors’ approach to the patient being in either physical or psychological terms. His opinion about this was very clear: “Well, I don’t want to be like that.” The context for that statement was as follows.
Do you have a sort of personal vision in the direction that you're moving? Enabling you to get past those things?
David: Yeah, I um, I see myself as a generalist, and the area of my medical practice that I saw as limited, was the area of my ability to deal with the psychological, emotional content that was presented in my practice from my patients.
I think that we've got a very good level of physical, biological information, and most of us do not have skills to the same level in the psychological and emotional side of things.
And from first base, general practice is holistic; general practitioners need to be good in both areas. It often tends to be one or the other, you know, you're a physical, biological doctor, or you're not good at that, not interested in it, and you're good on the psychological side.
Well, I don't want to be like that. And I think philosophically, the strength of general practice is it's ability to do both, and my vision has been to be good in both areas.

Robyn concurred with this in her interview, although she put this in a different way.

So you've got a fair philosophy of practice?
Yeah. And it's been really clarified [pause], you know, I've talked with (my supervisor) about that a lot in the last year.
Your philosophy of practice?
Robyn: Yeah. Just because I guess I've been really focused on it recently, and so we've talked about it a lot, because it's a forum where I can talk about it, and talking about it helps me get it clear.
And my clear philosophy is that my role is to be a facilitator for people to live their lives in the best way that they can, and that how I facilitate that is only limited by my imagination. There aren't boundaries on what I would consider in that facilitation – that's up to the patient and what they want.
You know, and so [pause] if they want me to be very western and conventional – then that's fine, you know, I can do that. I can do that easy. But if they want to talk to me about their spiritual well-being, then I'll do that. And I won't claim to be an expert, but I am very happy to talk to them about it, and see that it's part of their health – their global health picture.

So psychotherapy was now an integral part of her practice.

It's part of your professionalism (having supervision). And so you couldn't envision being a GP without it at the moment?
Robyn: But neither could I envisage being a GP, without doing a bit of psychotherapy, 'cause I think it's inherently part of the people's whole health thing.

In her day to day work, Lee saw the psychological in the physical.

Do you think having counselling skills now, has made you more effective with the purely physical patients?
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Lee: yes; in ‘purely’ physical problems there is a lot of patients’ fear and grief and responses to the illness they have – not many things are ‘purely’ physical – even cuts...

Mark re-framed a similar discussion into the capacity for “intimacy”; being available for patients whatever their presentation.

*How important is it for patients for you to be available for them?*
*Really, for all my patients, I should be in principle, available. But for me it’s a fundamental of general practice, because I cannot separate the person and their emotional needs, from whatever the clinical presentation is. Even if their emotional needs are ‘it’s not going to hurt me, when you give me the local anaesthetic is it doctor?’*

*So would that be a fair statement about your philosophy in medicine?*
*Mark: I think every patient comes in, with an element of anxiety about something. And, I’ve not completed my job on that day, unless I’ve addressed that anxiety, in one way or another. And that anxiety could be minuscule, or enormous, it could be [pause] the predominant reason for the consultation, or it could be merely associated with the consultation.*

Not surprisingly, this led to a discussion on his philosophy about the patient with poorly defined symptoms. In retrospect, I may have been rather too interpretive in my role as interviewer as I interpreted his approach as being that of a “psychological fundamentalist.” His explanation, however, illustrated a more considered approach to both physical and psychological problems. This is reproduced here in full, as his comments showed the professionalism and integrity of his work.

*Oh yes, there is a really fundamental thing, is that we all know the patients that come along with poorly defined disease, or symptoms. You know, they’re a diagnostic problem, and you look for the underlying cause. And I’m very aware that a lot of our colleagues have found media through which to work. I mean, some do acupuncture, (or) those who are diet organisers say ‘look, maybe we should look at your diet’... the osteopath says ‘perfectly clear why you’ve got chest pain – your back’s out’. For me, that medium, that follows naturally all the time is that if this person is non-specifically unwell, and I can’t really define what’s going on, my instinct is to say, what is going on in that person’s life that brings them here today, and makes them feel as they do.*

*So you say you’re a psychological fundamentalist?*
*Mark: I’ve never been called anything [laughter], but if I knew what a psychological fundamentalist was, I could well be one. [laughter]. It’s a term I coined up a while back, to explain the difference between going to the physician with chest pains, and it’s going to be cardiac; and going to the psychotherapist and the chest pains are going to be psychosomatic. So is that a fair statement? That your system is a psychotherapeutic one?
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Mark: um, pause, I think it would be dangerous to focus it too close there. I mean, if someone comes along, and I think, 'oh, this seems a very stressed person, I wonder if their chest pain is psychologically based'. My first thing will be to spend quite a lot of time focussing on the physical aspects, and saying - it's interesting, I wrote this (previously) on 'discuss the management of the tired patient'. If someone comes in – and here we’re talking tiredness now, rather than chest pain, but we could do the same – and my instinct is, that this person seems depressed, or it's a psychological base, I will initially screen the physical causes, and say 'well, hang on a moment, they could be anaemic, they could have glandular fever, they could blah-blah-blah', so let’s check that first. And having had a really good look at that, say ‘well, no, I haven’t found what I didn’t expect to find, so let’s have a look at what’s really going on’. If, on the other hand, someone comes in saying 'I’m just running out of energy - I’m tired, you know, I go to chop up a few blocks, and normally I can chop a whole block of firewood, but I just keep having to sit down'. My instinct, if a patient came like this, is that it is cancer of the bowel; my instinct is to think ‘well, that sounds pretty physical, let’s just check, fairly briefly, what his emotional world’s alright, and then we’ll get on to what I really think’s going on’. So; ‘yeah, that’s quite a problem, how are things generally?’

Mark’s approach then, was to include the importance of the patient’s narrative story, integrating that into his model of practice.

Learning to do psychotherapy also seemed to help these doctors with their routine general practice work. For example:

Lee: The fact that I was working so hard with psychotherapy patients meant that what I learnt in that process, I could apply with relative ease, to my routine general practice patients.

David was similar.

Did you, was there a conscious separation in the two styles of practice? Between your normal GP patients and your psychotherapy patients? David: Well it probably was, and the supervision related only to the management of the psychological issues, but, having done it now, it has transformed and revolutionised my practice in approach to all my other patients, who may never go anywhere near counselling. But my ability to listen to them and hear what they’re telling me, I hear so much more in a consultation now, than I used to hear...

I extract a lot more information out of a ten or fifteen minute consultation than I did before. So, I’ve actually got a lot more to work with, in terms of meeting that patient’s needs and devising, coming up with some sort of management program with them, as to what we’re going to do next...
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I’ve found that since I’ve had a counselling/psychotherapy focus, that my need for supervision (apart from just technical matters, you know, like what drug to give for this condition, or whatever) is actually far less, because what I’ve learned on the counselling/psychotherapy side of things has opened up so many more options in ways of dealing with a difficult patient.

He compared himself too, with peers who haven’t had this sort of training or focus.

I find that when my partners are presenting difficult patients, that I feel like I’m reading a situation very quickly, and I’ve got a good idea of exactly what I would do, and from my perspective, the options that I see and what the best option is, seems to me it’s much more clear to me, often—well, most of the time—than it is to the others, who haven’t done any of that sort of training.

David used listening skills within the normal general practice consultation.

I have much more focus on the emotional experience of the patients, as well as the physical symptoms that they’re talking about and how those two things relate together. I think I empathise with people better by sometimes intuiting the emotional content from the little bit’s of information that come through...what patients tell you, what they sometimes don’t tell you. I think I connect with them much better...I’m sure that engenders more confidence of the patient in me, that I’ve understood what they’re telling me, and therefore more confidence in the management as well.

Paul dealt with all aspects of illness with his patients.

Being involved, being there for a (patient), whatever they bring in really. Whatever they bring in...whatever they bring in, yeah...Might be physical, psychological. Yeah that’s right. Yeah, not getting frustrated if it’s sort of less than medical...

I mean it’s what they feel, and I’m very happy to get into that. And maybe, that they have to go and see someone else, but yeah... they might not have to either. So yeah, it’s taking people seriously I guess.

“Not being frustrated if it is less than medical” was perhaps a marker for the maturity of these GPs. As noted in the section on the culture of practice in New Zealand and how the younger GPs (the registrars) often attempted to reify their patient’s psychosocial issues into a disease (page 45), these GPs here were comfortable not to have biomedical explanations and were thus less inclined to over-investigate, or over-refer.

Lee summed up this section on these GPs working “with everything” that patients bring, and introduced the idea of having another agenda as well.

We’re trying to define the philosophy of supervision, or even a philosophy of practice, I suppose.

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Lee: Well, yeah, I suppose it is a philosophy of practice. I mean, what’s your purpose?
Lee: To get through the day as quickly as possible, so I can get home [laughter]...
No, well, my philosophy of practice would be, um, I suppose I’m particularly interested in the mind-body stuff really, and sort of, trying to um, [pause], work with everything. I mean, it actually causes a lot of stress because you’ve got a fifteen minute consultation... and I found that you’re still stuck to dealing mainly with physical medicine and form-filling, and just getting through what needs to be got through.

What do you mean by everything?
Lee: Well, just trying to get to what the real thing is that the person is dealing with...
Sometimes it is straightforward physical medicine, and that’s what’s needed, in fact, that’s what they’re coming for, but there’s often underlying, driving things in their lives, and a lot of people are conscious of that, too, if they have the opportunity, or somebody’s interested in that aspect of them as well. I mean, my most satisfying medicine is when I get to the point of moving from what people have come in with, to maybe having counselling sessions where it’s appropriate, because there’s a lot of other factors going on that are driving them to have some kind of thing that they present with – which might not necessarily be so physical, because it might be tiredness, or it might be sleep problems, or whatever...

This idea of “moving people” will be explored in the next section.

8.3 “Moving” patients
Not only did these doctors observe their patient’s stories; they also seemed to have the ability to help the patient recognise the importance of their own psycho-social issues.

In Chapter 3, these issues were explored in the context of somatisation, which is both one of the anomalies to biomedicine, as well as one of the more innovative emerging medical models in the last few decades (pages 31 and 34). As already noted, New Zealand has one of the leaders of this model in Dr Brian Broom from Christchurch, a consultant immunologist and qualified psychotherapist. His book is now one of the standard texts on somatisation (Broom, 1997). Some of the GPs in this study were aware of his work, and his influence on them was noticeable. In using a somatisation approach, doctors found their work both more challenging, as well as more satisfying, and the reasons for this become apparent below. In short, these GPs sometimes tried to “shift patients” from a physical focus to a more psychological one. Lee continued:
And how do you get people who have been thinking it's a physical problem to accept counselling?

A la Brian Broom really. Through honouring the physical, and honouring the psychological, isn’t it really. Like, take all aspects to use, and well, it’s an educating process for people – how many different things are driving what they’re presenting with – but also, sometimes people become clear, or it’s quite obvious, or they’re presenting something which is, sort of psychological really anyway.

So, people who are not so ‘that way’ bent, they’ll often – people who do get to counselling have quite an idea that there are things going on in their lives that might be driving their illness anyway, I would say.

And that’s more satisfying for you?

Lee: Much more satisfying, mmm, and I suppose that people (patients in the practice) over the years, are aware that I’m interested in that sort of stuff too.

So is the … is it dissatisfying to focus entirely on the physical?

Lee: Yeah, well, I find some physical stuff is very satisfying, like crushed toes and things [laughter], cutting moles out, and really nice practical physical stuff, but, I hate it when people’s physical symptoms are obviously psychologically related and you can’t get into that, 'cause they’re so defended against it, and that’s when I probably cut off from people. But I do like it, I do find most satisfying, the psychological work.

The pure psychological work? Or the psychological arising from physical?

Lee: Um, both, actually. Because I find like, often in just ordinary appointments, and in surgery, you can do a lot of work around the psychological stuff too.

So without being overly focused on the psychological side of things, Lee was more comfortable with both physical and psychological issues, getting satisfaction from working in the areas of overlap.

Robyn also found these patients to be a considerable challenge; at times she would see her psychotherapy patients in a different room to physically differentiate her role. She also identified just how difficult her task was with those patients.

They’re really, really hard to work with, because they haven’t been able to admit to themselves that they’ve got those psychological issues, so they have to get something physically wrong with them to get help.

So you’ve had to sell the idea of psychotherapy to them.

Robyn: Yeah, although, [pause] it’s not hard selling ‘cause they’re coming for help. They’ve often been through a whole lot of stuff, and they’re not getting better. So, it’s not that they’re resistant to the idea of psychotherapy, but I think if you look at what’s happened as people have learnt to compartmentalise themselves so effectively, that they have to get a pain or a disease in order to seek help, so even if they’re willing to accept that they’ll
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look at what’s going on, that their defensive layers are so thick that getting through them is really hard.

Robyn also had to work through her training about being the “Fix-it” person. As already noted, this is endemic in medicine, and it can be a considerable hindrance when doing psychotherapy.

And then, I’m a trained GP, and I come in with the fix-its. We get into a psychotherapeutic situation, and they’re the sort of person who’s spent their whole life asking people to help fix them, and in the beginning, we used to try and help fix them, and it’s exhausting, and you don’t get anywhere (laughter). So eventually I learnt that, perhaps, stop that. We’ll have to stop trying to fix them, and at the stage where I stopped trying to fix them, then I stopped trying to fix the patients in my office as well, because they’re the same people. They’re the same people, even if I’m changing my hats when I move between the rooms, they’re the same people, it’s the same issue.

So the effect on her ordinary practice from doing psychotherapy was that Robyn gradually learnt to let go of the Fix-it role. At the time I commented how clear she was about those issues.

I’m impressed with how clear you’re being with that, too.
Robyn: Well, this is after ten years hindsight.
It wasn’t so easy?
Robyn: It wasn’t so easy to start with.

David was also very articulate about the need to shift patients from one focus to another.

My ability to shift patients from the physical focus to the emotional focus is much greater, and to, in certain cases, to shift pretty defended people, bit by bit, into a place where they are willing to see a counsellor or a therapist to sort out the emotional issues. I find that a real challenge, and very rewarding, so it’s a skill I’ve got that I can use when needed and I feel really good about that.

In summary of this section, one can see the pride in their work. They had consciously moved away from a purely physical idiom, and got satisfaction from being able to work with patients’ emotional factors and being able to get patients to make the connections themselves between their feelings and physical symptoms. These GPs
then, are embodying some of the paradigm shifts that were posited (in theory) in Chapter 3.

8.4 The doctor-patient relationship

The considerations above assume that the doctor and the patient are involved in quite complex interactions. This section examines this in more detail, in terms of the doctor-patient relationship. All these GPs stressed the importance of interpersonal relationships and connections with their patients, and they had a method of working through any relationship difficulties. Historically, there is a link here to Balint in the 1950s. This section is related to the next one on the doctor-supervisor relationship and the parallels between the two will start to become more explicit. The focus for his section is at point 3 in the supervisory system, using the schema outlined in the last chapter. For example:

*How important is you developing a relationship with your patients?*

Paul: Oh, it’s everything really. It’s not everything, but it’s, it is very, it gives it.... Well again you’re getting into the story thing. And once you’re into a story it develops a richness on its own. And you get to know the person better too, and I think the actual, if you like what... you’re decision become more informed as well, because you know the person better over time.

This doctor valued the sense of his continuity of relationship to individual patients and to the community, as this excerpt illustrates.

Paul: I mean when I think of, I’m thinking of a young woman...with schizophrenia...But my memories in terms of continuity, are running around the garden at two or three in the morning trying to find her in the frost. (laughter). With her mother, with the moonlight over the hills in the background.

But I mean, this is my strange mind working, I mean it was, that’s the thing that comes back in, that’s what I remember about her schizophrenia.

And the same things happening now when I’ve seen young patients here, coming through. They say ‘Doctor, you delivered me’. I think, oh yeah, yeah. You know, and that actually gives you a real buzz.

There’s this whole sense of something just... there’s a sort of sense of continuity. It starts to all come together really. But I say, ‘god, he’s getting a bit sort of carried away that old GP, if he talks about those things’. But that’s what makes it for me anyway.

He also defined how “one-off” consultations have an impact on the doctor-patient relationship.
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But you, you’re a bit like a, someone standing at the, the signal- man really. And, I don’t. I’d actually like to talk to the people, engage a bit more. Not very satisfying.

No, it's not very satisfying, I think that in the end, if you’re able to engage with people then you actually get a better perspective of what their real health issues are, and you can be a lot better doctor, if we’re going to use that word. Being the devils advocate though, you could say that young patients don’t necessarily want a relationship?

Paul: No, no, sure. Well thinking that, you have to respect that. And I do.

So you’re guided by what they’re wanting?

Paul: Yeah. And I guess that supervision helps me to, to retain, I mean we talked about objectivity before, it does help. I mean there has to be a balance doesn’t it, that I mean, I need to maintain my objectivity, and not be you know, lost in the emotional stuff. Not get buried in it.

I asked most of these respondents about the doctor-patient relationship and John’s reply is as follows.

John: You can’t do anything without a relationship. I have always seen in terms of my general practice skills, I’ve always said my knowledge of fine print and medical textbooks is not good, I can not remember the fine print, if you want to ask me a detail about something I haven’t seen recently, I’ll have to go get the book out. The thing I do however, the thing I do value in my skills is that I think I have developed skills to enable people to tell me what’s wrong. I mean it’s no use knowing a textbook, if a patient can’t tell you what’s wrong with them. You only find out what’s wrong by developing a relationship.

He also linked this to his philosophy of medicine, distinguishing between the “magic bullet” philosophy, compared to the doctor accompanying patients “on their journey”.

As compared to the worst of the medical model that implies endpoints, you know so, you diagnose someone as being depressed and give them antidepressants which fixes it. That’s the worst example and it’s true if someone has an appendicitis and you operate on it and fix it, but I think we’ve generalised that sort of magic bullet sort of philosophy, and it doesn’t fit general practice. If you try and apply it to general practice you burn out and get depressed about this patient you’ve been trying to help for years and they’ve just had their leg chopped off because their diabetes has been poorly managed, and you feel guilty about it, somehow.

What crap, you know, all you can do is accompany them on their journey and if you get a really good relationship going and if they’re in a space to make
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\textit{some changes their journey might be better than it would have been without you going along.}

At the focus group, three of the participants agreed on the importance of “hanging in there” for the patient (as part of their commitment to the relationship).

\textit{F/Paul: I’ve got written down ‘commitment in spite of no diagnosis’. You know, it’s a sort of an expectation these days if you’re actually going to sort it out and put em into the Read Codes. (laughter). Sorry to bring the Read Codes back into it... You’re hanging in there and you’re taking them seriously, even if they’re the heart-sink sort of people that come in and you’re.....}

\textit{F/Robyn: You’re right, that you’re there for them.}

\textit{F/Marx: Then there’s this, the awful situations when you’re personally devastated for one reason for another, and you know that ‘I’m not here for this person tonight’. That’s scary isn’t that. Would anyone deny that that happens, that you’d like to feel like you think ‘I know I want to be there for this person, but there’s nothing left inside at this moment... I wonder how well we all deal with that?}

Unfortunately, that rather interesting question was never really answered, but it led to another issue. Mark noted that other professionals also have to engage deeply with their clients, and so they could also benefit from supervision. “Intimacy” here refers to the degree of professionally-bounded mutual understanding, rather than the intimacy of love-relationships.

\textit{So, if it’s a less intimate (professional) relationship, then there’s less requirement involved to go to your supervisor. Is that a principle really?}

\textit{Intimacy? And needing supervision?}

\textit{Mark: Um, you could say that anyone involved in person-centred work, could benefit from – not only they could benefit from, but their client could benefit from – them having supervision. (Someone) even suggested that maybe engineers and other people could benefit from supervision. The fact that they’re having to deal with clients. Or architects, or lawyers [laughter], all these people, I mean, any professional where they’re involved in a confidential sort of relationship, or a supportive, or a responsible relationship with their clients, could require it.}

\textit{I think, the deeper you get into intimacy, and the more interpersonal flux there is in a relationship, I think, the greater the need for supervision becomes. That’s the factor...but when we get into, recognising that you are actually forming psychotherapeutic contracts with clients, I think there’s a feeling in New Zealand now, that there’s an expectation you have supervision. I’m sure it’s not universal yet, but I don’t think it’d be far off.}

Mark was referring here to the psychotherapeutic community where supervision is a given part of professionalism. However one current IPA is now linking their
counselling subsidy to the requirement that the doctor has formal supervision (as previously noted). This managerial change has the potential to stimulate discussion on these issues and may force doctors to be explicit about their own professional support systems.

As part of the doctor-patient relationship, these doctors acknowledged that they self-disclose to their patients, during their work. They disclose about their own life-experiences where it is of benefit to the patient, and they disclose to their (counselling) clients that they have a supervisor who “oversees” their work.

Robyn: Well, that’s the open government that I’ve been rambling on about, I mean, that’s the same thing again. I have an entirely transparent relationship with my patients, where – have to be a little bit careful with it at times, in the sense that I don’t want to tell them about me inappropriately, where it’s not useful to them – I’m not trying to get them to fix me. But, I don’t think that there’s any aspect of my life that I’m not actually willing to talk about with a patient. Much to their surprise, at times [laughter].

Mark revealed that he self-disclosed quite frequently, and he would check with the supervisor that it was an appropriate thing to do.

Mark: I get my comfort from supervision, from being told ‘what you’re doing is valid’ or from being told ‘that’s inappropriate, maybe you’d do better not to do that’, I mean, I don’t think that this has ever happened, for instance, if I undergo a self-disclosure, I mean, I do self-disclosure very frequently, but that has always got to be specifically for the benefit of my client. If I start self-disclosing for my own needs, that’s totally inappropriate. That’s something I would expect to get out of supervision, and maybe, to get the words ‘yep, that seems alright’.

Here was an example.

Mark: A very good example is going back to this fellow who had trouble relating to people, and he talks about what it’s like for him when he goes to parties, that feeling of standing in the corner, and not being able to initiate conversations, and so on. And I said ‘hang on a moment, that is so familiar [laughter], if I think back to endless parties – this is very normal behaviour. The number of times I’ve felt like a fish out of water, when I’ve found it difficult to go up to someone and initiate conversation. The number of times I’ve told myself I’m happy just to watch other people at parties – it’s bloody awful isn’t it?’
Now, I'd say that was a self-disclosure, I would say it was also very creative for this fellow, 'cause he said 'oh, it's not just me?', and the answer is 'it's probably everyone at one time or another'. Now, that would be a self-disclosure, and not to make myself feel better that 'yeah, it happened to me too, mate', it was a way of helping my client.

He was also open about his supervisor to the clients.

Mark: I might have said 'you realise that I get supervision, and I do talk about the people I see with a supervisor' which I think, telling my clients should be a reassuring thing. I'm not completely mucking about in isolation. And, so 'he brought up something on reflection is quite important, that I'd like to look at, if that's okay.'

And by doing that, I'm hoping, revealing me as being completely open and guileless...open to change and someone we can trust, because I'm prepared to show my own processes you're transparent

Robyn was also transparent early on in the counselling relationship.

Robyn: I tell them about my relationship with my supervisor...I'm telling them about it, in order to create the same type of relationship.

So you're quite transparent, are you, with your patients?

Robyn: Mmm, absolutely...I think initially, the first time that I tell them about something like that, they're a bit surprised, and funny enough – well, not funny enough – they really like the idea that I have somebody who I employ to oversee me.

Do you tell them that, so that they know when they talk with you, you're gonna discuss it with (the supervisor), or do you tell them as an example of how you can get into a close therapeutic relationship?

Robyn: Both. All my counselling, all my psychotherapy clients, I tell within the first couple of sessions that I have supervision...

And that, I might discuss their situation with my supervisor. So, I mean, I always tell them about that, somewhere really early in the relationship.

Her next comments illustrated both being open to the patient, as well as leading into the next section on the importance of the supervisor-doctor relationship.

Robyn: I talk about my relationship with my supervisor with my patients and my clients. So when I do that, what I'm doing is telling them about my intimate professional relationship that I have with somebody, as a way of setting up the intimate professional relationship that I'm having with them.

David agreed. He was firstly talking here about medicine as an interpersonal relationship and then developed the idea that supervision is also based on "relationship."
David: Well, just in the way medicine really should be; it is an interpersonal relationship, it's not just the person with the technology giving it to the, you know, the biological organism with a problem.

And, so, supervision for me, I don’t want somebody who’s just, you know, has got the technological information in a way, who applies it to the problem that I present. Life’s more than that. Life’s richer than that. Life is essentially about relationships and in medicine, interpersonal connection and communication, your life and everything that you are connecting in some way, at some level, with this person and their life and everything that they are.

And, so I want my supervision actually, to be like that too, it’s got to be interpersonal, not just mechanistic.

It would be hard to sum up those concepts any better than David has done here. He has mentioned how life is “richer” than just the biological organism; “life is essentially about relationships”.

8.5 The doctor-supervisor relationship

The doctor-supervisor relationship is 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. The work from Doehrman (1976) illustrated how important this parallel process was between client, therapist and supervisor, and this section confirms that parallel process was also present in general practice supervision.

Firstly however, this section deals with trust while being challenged, and various supervisor techniques. I asked about the relationship with the supervisor in the focus group.

To be specific about it, what features do you people want in your relationship with your supervisor?

F/Robyn: The word that keeps jumping into my head is ‘safety’.... If I think about what makes supervision, well my supervision situation so powerful, is that it is an extremely safe forum for me to say whatever I want to say, and yet as Paul was just saying, what I say can be challenged in that forum, in a setting that’s safe.

Right.

So where I don’t feel like it’s a personal attack, but a discussion or an evaluation of the process that’s been going on...what makes it so powerful is the safety of the situation allows me to be extremely vulnerable, and through that vulnerability make changes if that’s appropriate.

Well that’s a pretty good summary.
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The issue here was how learning can occur. Given that these were mostly Otago graduates from an era in which safety in learning was not a prime consideration, it is to their credit that they have found a situation where they can be challenged in a safe environment. They were explicit they wanted to be challenged, but were equally adamant that the supportive relationship was in place beforehand.

F/Mark: I think an important I need from my supervisor is a preparedness to go for me as well (laughter). Not perceive me as vulnerable and treat me too gently, and the gripes that I’ve had from time to time in my Balint group is that, if you think up a problem and everyone would be very concerned to tell you how well you’d done and you’re okay and you’re a good guy... And in fact you say ‘Look would somebody actually tell me where I’ve screwed up?’ (laughter). And say, ‘yes you’ve screwed up, but it’s okay to screw up, but let’s look how you screwed up?’ And that’s what I really want from my supervisor, someone to say ‘now, stop it’, or ‘it’s not appropriate’.

F/Robyn: Yes, that’s what I was trying to say there, when I was saying that the relationship has to be safe enough that I’m not threatened by that.

Wendy was not at the focus group, but she had already expanded on this idea of “challenge in a supportive way” in her own interview some months before.

Wendy: Well, certainly...he constantly challenged my perceptions of what I was expected to do...He kept bringing it back to me, and I found it quite salutary because no-one’s ever asked me that before; asked me ‘why do I put up with it?’ or ‘why did I choose to be there?’ or ‘why did I choose to do it?’, in ways that no-one else had before, and I became aware that I always had more choice than I’d imagined. About the way in which I’ve worked...

So the focus is more on you? This sounds quite confrontational.

Wendy: It could be, but it was challenging in a supportive way. And although I felt challenged, I don’t think I felt bullied ever, or confronted in a way that wasn’t appropriate.

It was something uncomfortable, because I had to confront things that I didn’t – that challenged my strongly held illusions about life, but I like being challenged in that way, it’s something that suit’s me personally.

Your experience of supervision is that you didn’t feel vulnerable in that situation.

Wendy: No, I mean, I trusted my supervisor, I was really comfortable with him, that he cared for, and respected me as a person – he was simply offering me the opportunity to learn something different. I never felt criticised, just reminded.

And the other thing is, that it’s not a situation that’s forced on you, if I don’t like the supervision – well, I pay money for it at the end, and if I don’t like it, I can leave and find something that suit’s me. It’s actually my time that I’m
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purchasing. I feel I’m not a sort of, passive victim, and I’m allowed to say ‘I
don’t agree with you’. It’s a discussion, an informed learning opportunity.
Um, I don’t find it judgmental or threatening at all.

“Not finding it judgmental or threatening”. Paul agreed.

Paul: When I come back from supervision... I feel coming down the hill on my
bike... this (general practice) is worth doing, this is worthwhile.
You know what seems trivial, is not trivial, it is really... And it is hard work,
even just having, say, well look, dealing with those sorts of issues as you do,
person after person is hard work, cause you’re dealing with the guts of human
existence.
Well, just even to have that confirmation, rather than one of your colleagues
saying ‘God, I just had an afternoon of veritable cruds, you know....
That’s one perspective, the other perspective is ‘what I’m doing is
significant’.
Paul: Yeah, what I’m doing is significant. It’s worthwhile. Yeah.
That’s a pretty good outcome of supervision, I’d say....
Yeah, yep...

The following example of validation by the supervisor was when Robyn wanted to
review a particular incident; the outcomes of supervision (for the patient and for the
doctor) were mentioned at the end.

What’s the process of supervision in that situation?
Robyn: I’d say, ‘oh, something happened at the office the other day, that I
feel really bad about, and I think I should talk about it’.
What happens then?
Robyn: Oh, I’d probably give a quick outline of the background to the
incident arising, and then we’d normally play it out. I probably did both
roles, two chairs— me playing both roles, so that my supervisor could get a
feel of what was going on.
There was a building level of frustration going on in me in the situation, and
we talked about what I was feeling as that frustration was building as I was
playing ‘me’. And as, also as I was playing the patient, who was driving me
around the bend.
And, [pause], it was very interesting, ‘cause the patient was just crying and
wailing, and not wanting particular solutions to the problem that was going
on at the time. Her husband had decided that he would leave, and she had
turned up unexpectedly, having threatened the nurse with being suicidal, and
anyhow...
She wailed a lot... and so as I gave her some plans of action of what should
happen, she wailed some more. And in the end, in the constraints of my
general practice situation - where she was a squeezed-in patient, who had
been going for about three quarters of an hour at this time - I lost it, and went
‘for God’s sake, shut up and listen to me!’

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For many doctors, such an outburst could necessitate some later review of their actions and responses to that patient. Having regular supervision means there is an available forum for that sort of de-briefing.

So the outcome of you having supervision, in that particular case, has meant?
Robyn: Well, in fact, we decided that what I did wasn't unreasonable in this situation.
And I wasn't going to give them the solutions, you know. I was suggesting avenues that she could actually pursue for herself - I wasn't actually prepared to tell her what to do, or pursue avenues for her. So, I was requiring her to take a level of responsibility in the situation for herself, which she was not prepared to do.

So, supervision in this case, validated what you did.
Robyn: It validated, that's the word. And here was a situation where I actually felt really bad about this, but we discussed it at some length, and in fact, what I did wasn't as bad as what I thought. In fact, it wasn't inappropriate at all.
Because by the time we'd analysed what I'd done - I'd refused to be manipulated, and I'd drawn boundaries on what I was prepared to do, and I'd stuck to my guns, and at the end of the day, my outburst was actually to do with me sticking to my guns.

Okay, so did you see her again?
Robyn: No. And that was the expected outcome. When I talked about it in supervision, well, the probable outcome of this is that you won't see her again, because she now knows that you're not going to be manipulated.

So the outcome of supervision here, is that you go away, more easily minded about this patient, rather than giving yourself a hard time about what you did. The outcome was not necessarily for the patient, but it was for you.
Robyn: The outcome was for me, yeah.

The major point here was that the outcome was for the doctor, not for the patient. Furthermore, the validation can only occur if the supervisee values and respects their supervisor's opinion.

Paul and Robyn were quite open that they felt different in some ways to their peers; part of the function of supervision seemed to be to validate their own integrity as professionals. This has already been mentioned in Chapter 6, and here the emphasis is on how the relationship between supervisor and doctor could achieve that.

What's the particular features (supervision) where you can toss these things out, that makes it work for you?
F/Paul: That I'm not regarded a ‘twit’, or that what I'm saying is reasonable and may not be the way that everybody else seems to be thinking, but that what I say is taken and it is accepted and it's valued. I'm not being told that I'm naïve or that I've lost the plot or... that I need to come into line...
(I) do come into line, but I need to actually go somewhere to, to work it out for myself, which is going to be valid for me and it's going to help my practice rather than just be something I'm having to do for the system, whatever.

Any comments from anybody else on that?
F/Robyn: Listening to what you're saying there, it rings a lot of bells, similar feelings for me. Except that the end point of the process there for me is that supervision has reinforced for me that my thinking isn't like a lot of my colleagues, and that's okay.
Paul: Yeah, that's okay, that's right...
Robyn: And that I don’t turn around and say there’s a good reason for having Read Codes, I actually just go... (sighs)
There’s not, and it’s crazy, and the only reason I’m going to do it is because I’m being forced to, or whatever. That in a lot of ways, supervision has allowed me to reject practices that I consider ridiculous, but which might, for me to say that within a peer forum, might be considered to be all those things you just described, um, uncooperative, difficult, out of line.
Paul: Mmm, Yep.
So it’s kind of validating your misgivings about the, your current work structure.
F/Robyn: Yes.

Different supervisors did this in different ways. These doctors reported on quite different approaches to supervision. One of the early supervisors used books as a learning tool.

He used to put me in touch with books, um, that I could read, you know books on anger, and books on self-esteem, and that was for myself. But also, ah, (pause) I think he got me in touch with the stories, yeah the stories of, I mean you are, you are, when you’re working as a GP you’re very much involved with people’s stories, and, and if you like, it brought things alive in that sense, and there was a richness about the practice. A fascination I think, which he brought into things...

That supervisor was also able to broaden the focus of supervision.

But it also, enabled me to look at myself a bit, in terms of, what it was that drove me, ah, the whole guilt thing about saying no, feeling okay to say no. Cause, I grew up as a, I was a GP’s son... So, I guess I grew up under that shadow a bit, in terms of my not having difficulty saying no, getting the balance right, um. (He) would help me to get some picture of that, and get some understanding of what it was that, um, helped me to understand my
interactions with patients, e.g. the women who called me up all the time and visiting and (pause), get a sense of what really was important. So he kind of widened your perspective and gave you a different framework or something didn’t he...yeah... to look through. So he was pretty important to your professional development.

Paul: Yes, yes, very much so.

Mark’s supervisors structured the sessions in different ways. The supervisors here were S1 and S2.

The (second supervisor) imposed much more discipline on me. He, for instance, would say ‘when you bring someone to me, I want to know two things – the patient’s family structure, you know, the genogram of where they are, and I want to know what the contract is with your patient’. Very formalised. ‘Why have they come to see you, what is their reason for coming to see you?’ and it might sound rather Germanic, and I see you frowning, but, at the same time, it’s very easy for someone to come in the room and you start going through processes, but we’ve not really agreed on why we’re here together. Yeah, yeah.

And while I intuitively felt I knew why we were here together, I hadn’t actually discussed it with the clients, and that they knew why they were here... S2 was just formalising that, and he was formalising it again in his relationship with me, by saying to me ‘who am I meeting’ in terms of this patient. ‘What is your contract with them, and then I know what my contract is with you, about what is the question you bring.’

So it clarifies your purpose, which will in turn, clarify the client’s purpose in coming to see you?

Mark: Yes. And similarly it’ll clarify S1’s perception of his task, and it will be a very good way of modelling for me, that I must be aware of what my task is.

With his third supervisor (S3) the process was different again, where Mark worked from the patients’ notes. For example, after running through the notes about a patient, Mark was reminded about the client’s risk of suicide. Wanting to clarify whether or not having supervision made a difference for that patient (the outcome for the client), I asked if “that intervention made a difference.” Mark’s answer was to focus more on the process of counselling, rather than on outcomes, rather like the resource person at the educational session, mentioned at the beginning of this chapter.

Mark: How do I know, ultimately? Whether he came back, whether he was a different person? It’s a very difficult question to know what changes, what intervention makes a difference. Does it make a difference for the clients?
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Well, I mean, sometimes I get shown models of change, for instance, by my supervisor, which I can say ‘oh, right, that would fit very well with what’s going on here’, and I come and bring that model to the client...I mean, for instance, when I began to get a better understanding of the construct of transactional analysis, and I now bring it into a session, and find, wow, this is really good, it helps my couple understand much more about what’s going on with them.

That’s one aspect in which supervision can help, and actually make a difference. So, it is models, it’s also comfort – my comfort in the room, I think, is terribly important for my clients comfort in the room.

Mark was quite correct to say it is difficult to be definitive about outcomes of medical interventions. Instead, he outlined how important it is for the doctor to be comfortable in his role; having good back-up helps to achieve that, and it becomes more likely that there are better “outcomes” for the patients. To focus more on the process of the interaction rather than on behavioural outcomes was, in my view, an inspired solution to medicine’s over-investment in structural or biological outcomes, which while important, have considerable limitations.

8.5.1 Parallel process in the two relationships

The first part of this section has outlined features of the supervisor-doctor relationship (trust, challenge, different techniques, and outcomes). The second part now deals with the important concept of parallel process. This is where difficulties in the doctor-patient relationship can be enacted out in the supervisor-supervisee relationship; it is up to the supervisor to notice and to acknowledge what is happening, as sometimes this enactment is subconscious. In this way the supervision process will inform the supervisee of the issues at hand. As well, good supervision is a model of how the doctor can be for his or her own patients. Parallel process in supervision goes both ways (Doehrman, 1976).

The twist on that would be, if you went along to your supervisor (this is leading question) and took on the persona of the patient to some extent.

Has that happened to you?

Mark: It’s been recognised. I mean, SI will say, ‘hang on a moment, I’m confused. The way you’re coming across is confused to me, I’m wondering if that confusion is the patient’s confusion’.

That’s where he would recognise in me, features that I’m experiencing in the consultation, like, I’ve picked up the angst, or the issue from my client consultation, and I am now displaying it in myself.

Have you done that?
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Mark: Oh, that happens. And I've had that thrown back at me. In saying 'hang on a moment, am I talking to (Mark) now? Or am I talking to the patient?'

Parallel process leads in both directions. The supervisor is modelling a style of professionalism and a way of relating that the supervisee can enact out in his or her relationships with patients. Mark was particularly aware of this.

You said, let's say (S3) is listening to you – 'hopefully in the same way that you're listening to your clients'. Expand on that?

Mark: Well, I think it's fundamental, and it runs right through everything that we do in teaching, and therapy. It is the parallel process. I think you and I do understand the same thing by parallel process, I hope, that in supervision, I am experiencing something which my patients experience in therapy with me.

And I think it's one of the most fundamental aspects of supervision... So, I see that as incredibly important, and I also see the same thing in the process of teaching trainees. My process of listening to a trainee talk about the difficulties or challenges they've met with their patients. I hope that I will be modelling for them, what I hope they will be able to do, straightaway or in due course, with their patients, is active listening, and reflection, and not solving people's problems for them, but allowing them to find their own solutions themselves.

Well, is it possible to learn that act of listening, without having been listened to yourself? [pause], and how important is parallel process to your professional development?

Mark: I think that'll be different for different people, but certainly, when it happens well, it's a wonderful experience...

Similarly, with learning techniques, you've got the people who come along and say 'look I really want to feel more comfortable about one aspect or another, of working with patients, either general practice, or in therapy' and yet, you can open the door of experiencing the parallel process for them, which they never knew was there, and I hope that when that works really well, it's a totally uplifting experience.

I have had insight to parallel process for so long, but can't remember when I first learnt about it, first became aware of it, and the way I experience it, is when I'm having a session in supervision, and my supervisor uses a technique, or an approach, or an attitude, and I recognise it 'oh yeah, this is what he's doing to me, well, that's alright [laughter] I know what you're doing now', and respond to it creatively, and value it.

So according to Mark, parallel process was a way of learning as well. By experiencing a certain way of being with the supervisor, he could later model that back to his patients. He also included the idea of learning specific counselling techniques by first having them modelled to himself. This is a quite different method
to most teaching in medicine, where the didactic lecture (as the main teaching method) has dominated medical discourse. Unfortunately students could learn from that how to be didactic lecturers to their patients.

Robyn became aware of this “modelling” process by reflecting within our interview on her relationship with her supervisor.

Robyn: I trust that he won’t [pause], I was gonna say, challenge me too hard, but that’s not true ‘cause he challenges me enormously at times, but I trust that he will respect me – I think that’s what it is. And, [pause] developing that trust relationship takes time...

So being respected by your supervisor, and having trust with him, is an important part of your supervisory relationship.

Robyn: Absolutely.

Do you think that that model has rubbed off on you in terms of your relationships with your clients? I mean, do you think he’s modelling that in a conscious way?

Robyn: Yes. Oh, okay, I know it’s a leading question. I haven’t even thought of it, you know, but I mean, it’s obvious. I mean, the layers of supervision, the layers of the relationships.

I don’t know whether he does it consciously or not, because, I think that within his practice, a good psychotherapist treats all their clients with respect, and so, inherent in his practice, is treating whoever’s there with respect.

Her summary of this later in the interview was quite brilliant.

Robyn: Okay... I guess I could sum up in some ways. Have a see if there’s anything else. The process of supervision is about making an intimate relationship with your supervisor – an intimate personal relationship with your supervisor – and at a professional level, that’s a big start off, that’s a big step for medicine.

I mean, I can’t think of any other – I’m pushing to think about - I have intimate relationships with friends, and I have some colleagues who are friends, but this is an intimate professional relationship which is, I think, unique in that way.

And, in doing that, and in doing it safely within the supervision environment, it allows you to learn that you can actually do that within your office environment with your client – so, it’s a model of how you can actually run your professional life.

It’s almost like a statement, which is that ‘I can have quite a deep relationship with this patient, and yet, the boundary is that it’s a professional relationship, and it’s that intimate relationship that facilitates healing’ [laughter].

So Doehrman’s ground-breaking research (1976) has been enacted here in general practice supervision, where the intimate professional relationship with the supervisor enables these GPs to have a deep relationship with their patients. One can only
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wonder what happens to patients who are not on the receiving end of such committed and open GPs who are aware of the potential for professional intimacy and who do not shy away from professional commitment.

8.6 Reflective practice and experiential learning

These GPs used supervision to not only discuss their patients, but also as a place of dedicated reflective time, where they could review the cumulative effects of a busy practice. Learning was self-directed from their needs and from their experience. They demonstrated how they set the agenda, and how putting aside time for reflection was of value to them in their work. Here are three examples.

Lee: (Supervision) is a place to discuss...difficult relationships in general practice, and also – not just the individual patients, but the kind of cumulative effect of a whole session, type thing. It’s often good to go over a whole lot of other things about general practice.

David: Often, I don’t have time to think about things, you know, things crop up with counselling patients, or other patients, and I don’t necessarily have time to think about it, so supervision is a good place where I can acknowledge a difficulty, and go and talk it over with somebody, and actually I do my own thinking there as well...

F/Paul: You need to discuss it and explore it and find out really what is it you’re about, what is important? So you reflect on it and, I think if you like, you come up with some way of integrating that requirement, whatever ‘that’ is in inverted commas, with how it really is and/or what you feel is important for practice, or what you’re doing, and so you reflect on it and you come up with a new way of working which enables you to actually perhaps cater for both and also look after yourself.

I offered the term “cognitive restructuring” in the focus group to describe this.

Mmm, the phrase that came up...in the weekend was cognitive restructuring. Is that what you’re actually doing there?
F/Paul: Brainwashing.. (Laughter from others).
I mean you’re taking something that’s actually potentially quite problematic, and reviewing it in a different light, yeah brainwashing.
F/Paul: Yeah, no I don’t think it is brainwashing, it is actually...I mean I think it’s a constructive re, yeah a cognitive.... Yeah it’s a new way of looking at it, or another... or a way that fit’s really, I guess. You’re coming up with a another way, a cognitive reconstruction, it’s not really brainwashing, that’s a bad word really.
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In her own interview, Robyn gave a long account of how her thinking had changed over time. This involved ongoing experience, then reflection, then further experience, and so on. She was talking about gaining confidence in her counselling work. Her problem was that at least initially, she did not quite believe that she “could be non-directive and still help people.”

And, so, when suddenly, I put myself into the role of being a therapist, and was then suggested that I should be non-directive, a bit of me didn’t believe it – probably a large bit of me didn’t believe it...
(But) even if I labelled myself as not very competent at this, I was getting good outcomes with the people I was working with – so I can’t have been that incompetent... So, as I started to get some good long term outcomes, I started to feel more confident about what I was doing...
It was the very antithesis of how we do medicine...
I mean, part of supervision is that we try out little scenarios, different scenarios of how I might deal with the situation. So, I go back and try those out, and they work; and so then, I trust a bit more, in that non-directive type of process.
So, there was an evolution that had to take place, and as that evolution took place, then I became more confident in what I was doing, and then it wasn’t so threatening.

This was quite a good summary of how she learned to let go of being directive. It involved her trusting the long term learning process and trusting the supervisor.
Similarly, one could imagine the supervisor was at the same time trusting that she would “get the hang of it” eventually. His modelling (or conscious parallel process) was to be non-directive as a teacher, so the style of teaching would influence her subsequent style of practice.

David made some links with his experience and with his philosophy of practice.

My experience has informed my philosophy. There’s a dynamic between my experience and my philosophy, but they inform each other [laughter]

Mark almost repeated these words, although of course neither David nor Mark knew anything of the text of the other.

Mark: And everywhere, I’ve found it such a powerful tool, because it’s reinforced [pause], it’s been reinforced by my experience endlessly, as I’ve gone on developing as a doctor. And so, even though, going formally into
supervision only happened ten or fifteen years ago, involvement in these processes, and so on, has been part of my life all the way.

Both Wendy and Lee demonstrated how much they were in control of the learning situation.

Wendy: It's actually my time that I'm purchasing. I feel I'm not a sort of, passive victim, and I'm allowed to say 'I don't agree with you'. It's a discussion, an informed learning opportunity. I'm quite a - well, I didn't feel necessarily so much equal to the supervisor, but pretty close - that I chose to put him in the role of being slightly above, so that I could learn from him.

Lee: I learn more in that 'cause I'm working from sort of, where I'm at, I suppose, too; not from where I think I should be, or something. Experiential learning -based on my own practice and experience reviewed with a supervisor.

So it's set around your needs, is it? Is it a learning situation for you?

Lee: Yeah, definitely, it's a learning situation.

And it's a learning situation without a lot of the problems of shame and Lee: That's right, yep. Although this can arise and need to be dealt with in supervision.

Hearing others' perspectives had been a large part of the benefit for Wendy.

Wendy: It can be good fun, I've had a lot of laughs...But, you have the opportunity to think it through, talk it through, and have a perspective backing in a skilled way. Yeah. I think it's a good investment - I don't think it's overly expensive, it was costing me, what? $35 a fortnight to enhance my professional skills, relieve stress, maintain sanity and yeah, just learn a whole lot more about what it is to interact with people. I thought that was cheap. I think sharing a supervisor was good for me - I was refreshed by hearing somebody else's perspective, and their problems, and it put my own practice into perspective too - that other GPs have the same dilemmas and struggles that I do.

Mark enjoyed supervision because it was his preferred form of learning.

But what I'm saying is, I don't learn easily from books, videos bore me quite a lot, I love workshops, I love interaction with people. The peer group is my favourite form of learning. And supervision's that. My chosen interactive form with all the commercial content that goes along with learning, and the experiential learning, rather than didactic, or written learning.

Robyn set the agenda; supervision was related to her needs.

Do you think supervision is related to your needs?

Robyn: 'Cause I set the agenda. Supervision is related to my needs 'cause I set the agenda.
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This could be the definition of self-directed learning; "I set the agenda", although implicit in this was the idea that the supervisor will add perspectives that the supervisee was unaware of. If this was not the case, why go to supervision?

8.7 Roles and boundaries
These GPs worked hard to clarify the boundaries around their role as GPs. This statement contains two important concepts. As outlined in Chapter 2 on page 8, these are roles and boundaries, which are inter-related. What is the role of a doctor, and what are the legitimate boundaries around a doctor's work? Given the historical background to modern medicine, with the emphasis on bodily dysfunction and objectivity, it is perhaps not surprising how difficult it has been for these GPs to broaden their role to include an emphasis on non-physical aspects (feelings, intersubjectivity, empathy, relationships). So the first issue for them was to be aware of the narrow role that they had inherited as doctors, and to make a conscious decision to work in a larger paradigm. To be a doctor and a counsellor is to juggle quite different roles and these GPs have worked out ways of demarcating this. As already shown, at times they used different rooms for these different purposes. For example, one of the GPs used to do psychotherapy while in rural practice; it was important that both he and his patients were aware of which role he was in at any one time.

Initially...there was the difficulty that they were all the same people, and it certainly raised issues of role recognition, for both me and my patients, when I'm taking off my rural GP hat, and putting on my therapy hat, and it was important for them to understand that, and for me.

In general, doing medicine as a health professional has a different way of being, compared to doing counselling or doing psychotherapy. In medicine, the tradition has been to cure, to fix, to achieve an outcome, to be operatively involved, to alter the course of the disease, and so on. It is to be active and to be effective. Patients expect and even demand this type of intervention. Doctors advise and even tell patients what they should do. In counselling, most psychological traditions are the opposite; the therapist observes, explores and identifies the issues and the problems with the patient. However, even if the counsellor formulates some psychodynamic theory, it is still up to the patients to effect change in their lives; counsellors are not intended to be
overly directive (Rogers, 1976; Sweet, 1989). The boundary around the therapist’s brief is that he or she respects the client’s choice and volition. Robyn outlined how she worked through these issues with her supervisor, which in fact took some time to do.

In the early days, we spent a lot of time talking about how general practitioners have a ‘fix-it’ role, and how I found it difficult to change my hat, in a psychotherapy role, to stop being a ‘fix-it’. And for years, I think really, we talked about that trap for all doctor-players, in that stepping into the ‘fix-it’ role is very entrenched from the general practice perspective.

Later, her learning to let go of the “fix-it” role in psychotherapy started to rub off on how she worked as a doctor as well.

But the consequence of it, has been on my general practice, that I know I have a much less, um I’ve adopted the psychotherapy model within my general practice, so that my general practice has a much less fix-it role involved in it, because of what I’ve learnt in my psychotherapy. The practice of my general practice has changed because of the practice of my learning of psychotherapy, and I think that marriage has happened – I mean (my supervisor) was quite perceptive about those roles, and confronting about them all the time, he’d say ‘what are you trying to do here?’. It took me years to accept that with difficult patients, I couldn’t actually wear both hats, as a GP and a psychotherapist. It took me several years to accept that I had to move some of my general practice patients over to a different general practitioner when I worked with them in psychotherapy.

This is making a strong statement. She could not see the same patient for both psychotherapy and for ordinary general practice consultations. There was too big a difference in roles; the first perhaps could be labelled as “The Respectful Explorer”, while the traditional doctor’s role was more of “The Knowledgeable Consultant” or “Wise Director”. Defining and developing the doctors’ roles was a major focus for these GPs at their sessions of supervision.

Paul did not have hour-long counselling sessions with patients, but he was still very aware of his roles with his patients, and he listed some of these situations:

There’s issues like over-attachment. In a student who keeps, you know, where am I, am I father in the situation, or am I their...what am I when they come and see me? It becomes very difficult. The student with chronic fatigue, how do I deal with this, and keep it at arms length? The student who’s been
abused and brings me flowers, and those sorts of issues. And I find that very helpful to get some idea of boundaries and that sort of thing. 

So, you're just obviously trying to maintain your objectivity here? Is that what you're doing? 

Yes, that's right. And to remain safe.

What did it mean that a patient with a previous history of being abused brought him flowers? His safety was from being aware of the role that the patient was trying to give him, and of his own role in response to that. “Being the father” could be seen as transference; there are inherent dangers here for the naive health professional, but working through this transference with good interpersonal boundaries could be quite facilitative for the patient.

There were other boundaries that these GPs discussed in their interviews and in the focus group. The boundary between work and home was a legitimate focus in supervision. Paul again:

Supervision...almost gave me permission to have a medical life where I could have boundaries. It might be okay not to work in the evenings, or those sorts of things. 

How did supervision give you that permission? 

Because...part of supervision is caring for yourself. And I think it's very easy as a doc, not to care for ourselves, there's not a lot of nurture in there for ourselves. We just get out there and... I mean you'd meet somebody in the hospital corridor on a Saturday morning, and you'd say ‘How are things, oh busy isn't it’, and the guy would just carry on, and you'd think God, is this what it's like? Is this how it has to be for the rest of my.... 

So how does supervision actually do that? 

Well...if you're talking with someone, it says ‘Hey, I thought last week we said that you were, I mean you still seem to be doing things because you feel you should do them, now do you really need to do them’, I mean that's the sort of thing, the feedback that I get a lot of the time.

The boundary between work and home life was directly challenged by supervision. This helped these GPs find time for their own nurture:

And there’s a whole other part of me that needs nurturing, I mean, I’m keen on mountains, and all those sorts of things. There’s quite a strong other bit, which if it doesn’t get nurture, I’m afraid I start to lose it. But I can easily get on a high and keep on working harder and harder and then crunch, you know.
The focus group spent some time on doctors as patients. The discussion included an analysis of roles; can the unwell doctor change roles to be “the patient?” Secondly, can the attending doctor maintain his doctor-role in the doctor-patient interaction, without talking shop as colleague-to-colleague? One respondent felt that in general, doctors “do not hold” their roles very well, as the following case illustrated.

And even my orthopaedic surgeon (when I had a broken arm) didn’t hold his role. I mean he had to discuss other patients with me when I was there and tell me other orthopaedic stories and things. You know, and treat me as a colleague. And not as a patient.
So that’s the problem with... I mean for me that’s one of the things that I learn in supervision. Just um, you know appropriate roles for the appropriate situation. And I don’t think that lots of doctors understand that idea at all.

Holding one’s role as a doctor can be challenged when the patient is another colleague. I asked Robyn why doctors are so difficult as patients.

**Why are doctors as patients more difficult?**
Because they’re difficult. [laughter]
‘Cause they don’t respect the boundaries, that actually patients respect better.
I think it’s sort of inherent in that collegial relationship, where in a collegial relationship, we don’t have those boundaries – we’re colleagues. And yet, here we have a doctor-patient relationship where we’re not colleagues actually. So there was big boundary problems on their part, and me not knowing how to enforce the boundaries.
**So supervision was very helpful there?**
I think, in this sense it’s fairly simple, it’s that this is a professional relationship that we’re having here, and in a professional relationship, I see people at my office, and they come at the time that they agree to come, and that I agree to see them, and make appointments, and do that sort of stuff – that’s a part of the professional relationship. That’s the relationship that we’re having in that situation, and that it’s therefore inappropriate to come to my house if I’m not on duty, or even if I am on duty, without ringing to make an appointment, and arrange a time, and stuff like that. [Other patients wouldn’t do that ] Other patients wouldn’t do that, so there’s no reason why they should.

Robyn had experienced both sides (of colleague as patient), and supervision had helped her understanding of the roles and boundaries in those situations. This understanding helped the patients who came to her for treatment, and it helped her work through any role ambiguity when she was a patient herself. Role-challenges also occur for GPs if the patient was suffering a great deal; the doctor can feel overwhelmed, as Wendy pointed out.
I feel more capable of standing alongside peoples’ suffering rather than being overwhelmed by it. I don’t think I was doing anybody a favour when I was being overwhelmed. I mean, standing alongside is a really good metaphor. I need to be standing alongside them, I need to walk with them, instead of lying down beside them. [being walked over] Yeah, I need to be present, and empathic, but they need me to be in my role, and need me to be the doctor and have some strength to stand beside them, rather than getting lost in their suffering with them.

The following case scenario illustrated her shift in boundaries.

The classic example, that is one of my patients had recurrent vomiting, for about three months, and it was undiagnosed, and she went to hospital dehydrated two or three times, but they still couldn’t work out what was wrong with her. Finally, somebody found that she had a cancer in her duodenum; really, really rare tumour, and she was thirty-two. And I remember going home – driving home in tears because this really young woman had cancer. And she was thrilled to bits. ’If I can have it out I can stop throwing up!’. Two weeks after her operation, she was off playing hockey... the surgeon nearly died of shock, that she has gone from strength to strength, it really didn’t bother her, it worry her that she had cancer – she just wanted to stop throwing up.

And I was the one who went home in tears, and she was delighted that she had found a solution to her problem, and it would finally go away. She now has a recurrence, and that’s not as good a feeling. And it’s been interesting for me to see the change in my attitude that she has a recurrence and that’s her problem, work with it, and I’ll be her doctor, in my role as doctor, but I no longer go home in tears because of her problem anymore.

So micro-boundary stuff is to me, is what to do with over-empathising with people’s pain, and going home at the end of the day tired and distressed, because I’ve absorbed other people’s distress all day.

Other issues were being invited to weddings and parties by patients, and another similar challenge was when the patient was a friend. Most of the GPs here reported how difficult that can be, and how supervision helped to firm up the doctor’s role.

Wendy again.

I’ve got one friend who tests the limit’s of that, because she comes for non-medical things – like the occasional certificate, and she came for a smear the other day. ‘I said; ‘Oh, look, this is outside our agreement, what if I miss a cancer of something, this isn’t really ok. Next time you need something like this you should see your own doctor’. She has another doctor as well, it’s a case of double dipping.
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After hours work can be a further area where roles need to be defined, especially in rural practice, where it is possible to be on call twenty-four hours a day, seven days a week. Even if the doctor in a nearby town is officially designated to be on call, patients may still walk up the drive at night expecting help. One of these GPs had worked out some clear boundaries around this; for small things in that situation she would send the patient to the other doctor, but for clear emergencies she would do what was required.

So, this boundary is a clarification for yourself, a more important part of rural practice.
Well, I think it's important to survival, 'cause, I mean, what happens, is, because I'm quite clear on what I will and won't do, then the patient's quite clear about what I will and won't do.
And after a couple of years, the only people that land on my doorstep are – either the ones who are new to town, and haven't learnt the rules yet, or are the ones who have really serious things, who know I'll take care of them because they've got really serious things, so, I set my boundaries, and they respect them.
(For example), someone came to the door when I was cooking dinner one night, and it was 'oh god, someone's coming up the driveway, I'm not on duty, what do they want', 'cause it's always, still a challenge to tell them to go away. And I opened the door, and the lady said, 'my husband dislocated his shoulder down at touch-rugby, and the doctor is on duty 30 kilometres down the road'.
It's like, 'oh, okay, I'll come down and put his shoulder in'. So it's flexible, but I have boundaries, and I know other GPs in other rural places who are unable to do that – somebody comes to the door, then, they stitch their finger up, or whatever it is.

A powerful word on this was from Lee, whose boundaries included who she would or would not see as a doctor or as a counsellor.

One of the big things that I've learnt, is that I don't have to actually see everybody. I've turned a few people away since starting supervision, people I know I'm not going to work well with.

How do you decide to do that?
Well, [pause], I can just tell at the beginning. [laughter] They're people who come along for the first appointment to see if I'll be their GP...and so I've said, 'no, I don't think this is going to work'.
I can remember one person who came to check me out, and sort of goes on into all the sort of difficulties she's had. And I know I'm not developing a relationship with her that's workable from my point of view.
I think this is from (one of my supervisors). I've learned a lot from him. That if I don't like somebody, it's not going to work, it's not going to be a
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constructive relationship, so it’s best not to do it. And in a main town, where people have got plenty of choice of a GP, so why should I see somebody I don’t like? For whatever reason.

So it gets you away from your role of being all people to all persons?

Mmm, and my major criteria for seeing somebody for ongoing counselling, is that I like them. It’s my first, basic thing, that has to be fulfilled. [laughter]. I’d refer them to somebody else.

I mean, I think I have to, like and be looking forward to a certain extent, to seeing them a bit more, to be able to be a good thing. And that’s what I’ve learnt from supervision.

While this last illustration may seem a bit arbitrary, my lasting impression from the interviews and from these quotes is the degree of underlying respect these GPs have for their patients and for the work that they do with them. As Robyn noted;

Boundaries to me, are connected with respect. Once you learn to have complete respect for the patient, or the client, then boundaries are not an issue, from my point of view. Because, I’m not going to do anything, where I’m not going to keep them fully informed, I’m not going to do anything where I’m going to have a secret agenda, or that I’m only going to give them part of the information. I’m not going to do any of that, if I have complete respect for them.

As I have already pointed out, learning to respect the patient was strongly influenced by the respect that these GPs received from their own supervisors.

8.8 GP as healer

It was some way into the interviews before these GPs talked about “healing”, and they generally did so quite tentatively (perhaps to see if I was receptive to the concept) and almost with shyness. Overall, they seemed to facilitate healing or recovery of their patients through the interpersonal relationship. While “cure” is a more acceptable or traditional goal in medicine, healing has personal and spiritual associations. Defining themselves as healers was to immediately place themselves out of the mainstream, but once the topic was open, they were quite articulate about their role as healer. In the conversation with Lee, we were talking about getting to the real issues facing that patient (in contrast to not being at that point at other times).

I’ve got to a point where I really like it, because I think that we’re getting to something that’s really valuable.
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Why is that valuable for patients? To reach that point?
Because it’s um, it’s usually something of great significance, which is quite emotionally loaded, sort of thing, as it’s often lack of being at that sort of point to things being somatized, or causing their sleep disturbance, or whatever. And it often helps people’s awareness of their own, of what’s most important for them. Yeah, so people become aware of what they’re really dealing with.

So, that’s part of their personal journey, or recovery?
Yeah, well I’d say it would be part of their personal journey, and healing, and rising to a more increasing consciousness.

So you perceive your role there as facilitating them to do that?
Yeah. I think it is the role of a healer. [laughter]. No, I see my role as facilitating people to do that. It’s like getting down to what’s the real issue of what people have come along about.

Some of these GPs did video review of consultations for the RNZCGP, and so had an extraordinary insight into other doctors’ consulting styles. In particular, they could observe how deeply other GPs discussed any personal issues with the patient, and how they “closed off” the conversation.

They’re wanting to do the good job, and they’re asking the questions, and as soon as stuff comes up, they close it off, by some laugh or joke, or minimising something – something which isn’t what they want to do, but it’s something that they do, I would say.

That arises from what?
Well, I would say anxiety about, I don’t know, well, probably a lack of comfort in that area... I think more of a nervousness, or a discomfort with it, because, or a fear about taking the time, too. But, I mean, these are the issues that I’ve had earlier too. Maybe also a lack of legitimacy – and a lack of training and experience.

Without exception in this study, these GPs seemed unafraid to explore the patients’ feelings and personal issues without cutting off their cues and prompts. In the patient-centred model from the Canadians (Stewart et al, 1995), this is an aspect of their first task (exploring the patient’s perception of illness, see page 37). Significantly perhaps, though, Stewart et al did not mention healing as a specific agenda in doing so, perhaps also due to the reservations above on what is legitimated terminology in medical culture.

Part of healing seemed to be the idea of “sitting with”, or validating the patient’s distress. Lee, for example, had to work through her own reservations before she could sit with another person’s distress.
You can sit with the distressed quite easily. How did you develop that skill? Probably by learning to sit with my own distress. [laughter] and knowing that that is what's needed really. That we run away from distress a lot.

Sitting with distress was crucial to the idea of healing, as was the idea that it does not necessarily take a lot of time, as is mentioned here.

But I um, I mean me, having gone through supervision, plus my own personal stuff in group work, and being quite comfortable with those areas, I think, so when people's distress emerges, I'm quite happy with, and don't run away from it, and it doesn't necessarily take time.

So it's not something that I get afraid of, and feel I've got to cut off with people. But you also don't necessarily need to go deeply into things either, but often just acknowledging, and being with, and not having to do anything about it.

I suppose I develop a lot of ability to just, sort of, stick there, with people and not, you know, need to get away from it.

"Being with" rather than "doing to", has been a subtext in previous sections (the doctor-patient relationship, and the supervisor-doctor relationship), but here the process (of just being) is central to the intended outcome of patient healing.

Paradoxically, the health professional seems most effective when he or she does not try to change or alter the patient (Schainberg, 1983). Simple acknowledgement of feelings and issues, while hard for doctors to do, seems to be a powerful intervention. The thread to this goes back as far as Balint in the 1950s, who urged the GPs in his groups to attend not only to patients' medical conditions but also to their affect and their relationships. As Schainberg put it; "the doing is in the being" (page 235).

David put this in his own way.

I mean, everybody's got a world view, some sense of what the ultimate meaning and purpose in life is...I want to be open to that and be able to listen and connect with it, just in a way that patients feel healed to some degree, by the fact that somebody has listened and validated their concern....

Once again, there is an interesting slant on this from considering what happens when the patient (expecting healing) is him- or herself a doctor. One of the GPs here had a cardiac condition and so needed to see medics quite regularly. He noted how difficult
It was for them to treat him as a patient and not a colleague, which made any facilitation or acknowledgement (let alone any healing) more problematic.

We've had a series of young GP's -- they're only being there temporarily, waiting for the final person to arrive (whoever that is). But honestly shiv/quivering in their boots when they meet me. I'm trying to sort of say 'Look just treat me like a patient', but they, I'm not sure whether they're talking to me like a consultant or I mean, I find it quite difficult.

And they say 'what do you want to do with your pills?' And I say 'I don't know'....

So I think it's very difficult both ways. And I actually, what I would like is somebody who's a bit more senior than some of these people that I meet, but they're probably more up with the play than somebody who is older. But I just find it quite difficult...

The roles of the doctor that are required for healing to occur then, are a mixture of "Clear Observer", "Wise Clinician", and "Facilitative Acknowledger". The juxtaposition of objectivity and subjectivity, or detachment and involvement, is one of the difficult tasks of all helping professionals.

Mark talked about "professional intimacy" where there was closeness without crossing any social or physical boundaries. He linked this to being available for the patient, and to be aware of when not to probe.

Intimacy, is entailed in every consultation to a greater or lesser extent, and the challenge there, assuming one is open to intimacy -- and I'm talking essentially professional intimacy, I'm not talking crossing boundaries. Yeah, yeah.

Okay, I mean, I like to feel that, in any consultation, I'm completely open to whatever intimacy the patient is prepared to do. I'm, at the same time, anxious that I don't offer that intimacy in such a way that leads patients beyond their comfort, and start probing inappropriately.

So intimacy is all about sensitivity -- what's right to this patient, what comfortable, and it's availability without imposition, and without making the patient feel 'oh, well, I suppose I have to tell him'.

Paul's phrase for this was "magic"; he thought that doctors could trivialise their work with patients and so miss the moments of magic.

(Those doctors) often present with quite a strong front, as if they've got it all sussed. But I don't think they have really. I think they can look at the world too cynically. It's like as if they, um, they start to trivialise, I guess that's what I've noticed, and so they lose that, well I sometimes call it magic, it's in...
there somewhere, but if you can actually key into that, and realise that it’s there. It makes the whole thing worthwhile really. The magic to do what?
I guess in any general practice when you get um, busy, is that you can become overworked and you can just start to ‘see’ things. ‘Oh, just another bit of old crumble coming in the door’, (in geriatrics), or just, ‘I had a kid with a bloody sore throat and God, you wonder why they come in within 12 hours of getting a sore throat’.
But, you know, well, ‘what is it’, that does bring them in 12 hours…. I mean that’s probably more important.
And, if you’re not actually looking at that, it’s more, ‘what a waste of my time’, and so your whole thing is ‘what a waste of my time seeing all these people’.
I don’t know how you can work like that, you see.

In the interview we linked this back again to the contribution from Balint.

So, what does it do for the patient when you find the magic?
Oh, it’s magic. It, yeah, well that’s right, well it. Yeah, there’s that moment, or what we call ‘denouement’, you know where the person lights up, and you can just see them light up. Or they may, you just realise you’re on the same, and they’re actually about what you’ve said, or um, reflecting...
And Balint talks about that as the ‘flash’, doesn’t he....
That’s right, yeah. Yeah, and it may be that they’ve only just decided that well, okay, it’s a reason, okay, I don’t need antibiotics for this sore throat, and I will persist with taking the panadol...
And they’re accepting it as a reasonable thing. Not sort of saying well, I want the antibiotics...you know, not sort of moving until you write the script out sort of thing.

As it transpired, I had already discussed this sort of thing with Robyn, some months before. She had been talking about a moment of healing between her and a profoundly depressed patient. Robyn had got up from her counsellor’s chair, given the patient a hug, and said how much she cared about her. That moment was the turning point in the patient’s recovery.

It was a profound turning point, from where I can see.
Yeah, it was.
Almost like a ‘Balint’ flash of recognition between two patients, two people, which can be profoundly important to the patient...
And she’d been winding down into this spiral, I’d been trying really hard to get her out of it; and I knew when I was trying that that was wrong, and I knew that I was trying to ‘fix it’ again; and once I’d recognised that I was trying too hard, that was the liberating bit – okay, I’m trying too hard, there’s an answer here somewhere.
Was it hard for you to do?
No, but it was very conscious. It was like in slow motion...And, it needed to be really calm, and it needed to be really smooth, and I needed to tell her that I cared about her, and she came back, and it'd turned the corner. So it is like one of those healing moments that you were talking about, with the big flash.

To summarise this section, healing was not a word that these GPs used lightly. It was profoundly based on respect within the therapeutic relationship, and one route to it was to sit with patients' distress without closing them off. The magic or healing flash seemed to come from acknowledgement of the patient's suffering without any agenda to fix-it.

This chapter has been an attempt to tease out the features of a "supervised practice", where the practitioner incorporated the supervisor into his/her work on minute by minute basis. This incorporation was from mentally reviewing other similar patients the doctors had seen, remembering previous discussion with the supervisor, and imagining what the supervisor would say in the current situation. As well, the supervisor was a sounding board, or a safety net for a wide range of practice difficulties. The shift in focus for these GPs to a relationship-based philosophy of care was epitomised by their ongoing commitment to being in a supportive relationship themselves. They also described their role as healer in the community, and were quite clear about the boundaries of their work. One of the methods of facilitation of others seemed to be via the concept of professional intimacy.

8.9 Professional intimacy

As noted in Chapter 3, the history of medicine has been characterised by detachment and objectivity between doctor and patient, as part of the epistemological tradition of a rational science. Relationships with patients have until recently, been almost unworthy of mention, and teaching via the relationship would have been considered sacrilegious. Yet one ongoing criticism of doctors in the last fifty years has been their lack of involvement and their apparent detachment, with Mrs Brohm being a classic example (page 22). It is likely that superficial and shallow teacher-student relationships lead to superficial and shallow doctor-patient relationships, as this is what the students subjectively experience. Supervision asks a much greater challenge
of the learner, so it is not surprising that there are so many barriers to doing so. These respondents acknowledge that professional intimacy is a necessary part of practice and of learning, and this seems a long way conceptually from traditional medical teaching. As Schwenk and Whitman (1987) stated; “teachers who are professionally intimate bring authenticity to the teacher-student relationship”, but such comments are relatively uncommon in medical texts.

8.10 Vulnerability and strength, privacy and self-disclosure

Further to the paradoxes mentioned in discussion in Chapter 6 (page 112), there was an ongoing thread throughout the stories presented here of openness, self-disclosure, willingness to admit to mistakes and uncertainty, and a sense of vulnerability. John was quite explicit about the role of the “mother-confessor” in relation to vulnerability; “So that’s the mother confessor role of opening myself up, I’m comfortable being vulnerable, because I trust her obviously”. Similarly, most of these GPs explicitly mentioned their own use of self-disclosure in service of the patient, and all of them disclose their uncertainties and unsureness to their supervisors. Some also were quite open about their use of counsellors for personal help. Yet my own view of these GPs was that they were all quite powerful and effective practitioners, and I am sure that this view is borne out by the testimonies presented in this thesis.

To say the least, this is a curious paradox. Perhaps it is from continued self-reflection, where they become more and more comfortable with “not knowing”. Perhaps it relates to the ongoing trust within the supervisory relationship, where no matter how “incompetent” the practitioner may feel, he or she is still supported and the issues are dealt with proactively. Part of learning in such a way is dependent though, on adequate disclosure from the learner. As this gets reinforced as being a safe thing to do, and as the supervisee realises that the learning outcomes are worthwhile, then the process becomes self-generating. A possible learning cycle here would include practice difficulties, followed by self-awareness, then discussion, more self-awareness, and finally new options could be considered.
Schwenk and Whitman (1987) similarly considered this paradox with respect to self-disclosure in teaching; "The paradox of the teacher-learner relationship is that learners view teachers as more experienced when they reveal errors, more knowledgeable when they admit deficiencies, more powerful when they reveal weaknesses, and more influential when they say 'I don't know' " (Schwenk and Whitman, 1987, page 50). In medicine until more recently however, saying, "I don't know" would have been an admission of weakness and incompetence (Schwenk and Whitman, 1987; Sinclair 1997). Roles such as "The Reluctant Admitter of Ignorance" would have been well developed, while "The Cheerful Admitter of Ignorance" would have been absent. Yet clearly practitioners can never know all there is to know, and it becomes necessary to develop ways of coping with that disjunction. Supervision seems to be a method par excellence of learning to cope with the inevitable problems of "not knowing" in practice, through judicious use of self-disclosure and increasing self-awareness. The resolution of the paradox of vulnerability versus strength may be that it is only through self-knowledge that one is authentically powerful, and that defended ignorance is ultimately unhelpful to the practitioner and to the patient.

8.11 The supervised practice as an emerging medical paradigm

The reason for the extended chapter on the philosophy of medicine will now become clear. Referring back to the definition of biomedicine on page 20, these practitioners seemed to be in a quite different mode of practice. While it could be argued that that definition (McWhinney, 1983) is now an inappropriate description of twentieth century medicine, it could be also argued that the anomalies (page 31) are still present, that practitioners are still required to categorise their consultations on an entirely biological basis (see Paul's comments about Read codes on page 149), that guidelines and evidence-based medicine are still founded almost entirely on a positivist and rationalist view of the patient (Basky, 1999), and that problems with the "difficult" patient remain unresolved by the continued exclusion of soteriological dimensions from health care (Butler and Evans, 1999). In other words, biomedicine is still the predominant medical paradigm, despite strenuous efforts by Balint (1957), Broom (1997), Cassell (1976; 1991), Engel (1977), and Stewart et al (1995), to change medical thinking.
CHAPTER 8: The supervised practice

I have described the supervised practice in some detail. Several of the features listed in the results indicate that these practitioners had incorporated biomedicine into a different philosophical framework. This is not to say that they did not use the gains and benefits of reductionist medical science where appropriate. Rather, that that knowledge was embedded into a larger conceptual outline, where both physical and other dimensions were now considered to be relevant.

Referring back again to the anomalies on page 31, it seems that those factors were no longer such a problem for the practitioners listed here. For example, these GPs appeared to be comfortable with patients being unwell without an identifiable disease. They work specifically with the somatising patient to resolve the mind/body dualism that has been pervasive in medical discourse for several hundred years. They based their philosophy of practice on the doctor-patient interaction, being aware that the interaction between doctor and patient will profoundly influence the outcomes. They used self-disclosure judiciously for the benefit of patient understanding. They seemed to be a long way from “a detached neutral observer” (page 20), and were able to juggle the subtleties of subjectivity and objectivity as required (see for example, Paul’s comments on page 190). They defined their role in the context of the health care community, rather than as a disembodied biomedical scientist. They included a role for themselves as healer, something quite foreign to the traditional philosophy of medical cure. Lastly, they saw healing as part of the therapeutic triad between patient, doctor and supervisor. Robyn’s quote is worth repeating here.

*I can have quite a deep relationship with this patient, and yet, the boundary is that it’s a professional relationship, and it’s that intimate relationship that facilitates healing.*

So rather than the unsupported and isolated health professional working alone with patient after difficult patient, struggling to reconcile the patient’s angst into arbitrary notions solely of disease, these GPs were held and supported in a different way of practice. Patients, in this worldview, suffer from illnesses arising from the complex matrix of cultural beliefs and biological systems, with the interaction between patient and doctor having a profound impact on the subsequent course and outcomes of illness. These GPs have incorporated many of the seminal ideas of the medical
innovators listed above. For example, they included structured reflection on their work (a la Balint), they were aware of somatisation (Broom, 1997), they worked with the illness and disease distinction on a daily basis, their purpose was the relief of suffering (Cassell, 1976) and they were quite clearly patient-centred (Stewart et al, 1995).

The following aspects about such an epistemology of practice are related to various points in Chapter 3. For example, it would be interesting to speculate how these GPs would approach the “problem” of Mrs Brohm (page 22). I imagine that they would enquire further about her personal beliefs that led her to reject the mastectomy, and that continued respect for her choices would be part of the ongoing negotiation of management (while acknowledging that mastectomy may in fact, be the best physical choice at present). In terms of postulates (page 25), their practice would appear to located more in a subjectivist paradigm, with an epistemology of interdependence between the knower and what is known. Values would be included, both the values of the patient and of the health professional, while human nature would be seen more as voluntarism than of determinism. Idiographic explanations of illness would be accepted rather than searching for universal “laws” of disease. In other words, they would be utilising the last fifty years of innovations about medical practice in an enlarged medical paradigm, based on some quite different underlying postulates and assumptions.

What sort of paradigm is this? I have already outlined what I believe is the definition of a social constructivist medical paradigm (page 40), and this appears to be an adequate framework for the observed styles of practice in this research. However, these GPs have not described their work in these terms, nor have they commented on this framework to date, because at the time of the focus group, such conceptual frameworks had not become apparent. It will be interesting to receive further feedback when they receive a copy of the completed thesis.

These GPs seemed quite comfortable about their behaviours and actions (regardless of how their practice could be described), and they certainly gained validation and confidence about their work from the supervisory process. In contrast, the current
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culture of general practice in New Zealand outlined in Chapter 3 (pages 46-9) seemed rather depressing; an unsettled incoherent culture, intruded by recent managerial paradigms, and with evidence of individual stress and burnout (O’Hagan and Richards, 1997). Perhaps New Zealand is following the UK trend of the 1980s, where general practice was as Freeman (1998) noted; “a beleaguered profession mourning its lost image.” On the other hand, the respondents here each seemed to have a high morale, rather than a low one; they seemed clear about their purpose as helping professionals, and the philosophical disjunctions between theory and practice were being resolved.

8.12 Summary
The supervised practice illustrated here seemed to be a worked example of a social constructivist medical paradigm. The GPs incorporated reflective learning with less emphasis solely on biological determinants of disease, but with an added emphasis on individual values and mutual construction of outcomes from the consultation. Having coherence between theory and practice appeared to be resolving some of the unacknowledged tensions in current general practice. Further implications of this will be considered in Chapter 11.

The final chapter of results includes a summary of the data leading to a definition of supervision in general practice.
CHAPTER 9: Defining supervision in general practice

David: Supervision can highlight areas I need to deal with in myself, but doesn't spend time on those areas. I would need to sort it out myself, or seek specific psychotherapy for them.

This chapter further defines the concept of general practice supervision, by comparing it to other forms of professional and personal support. As noted already, these GPs had had considerable experience of many forms of professional maintenance. In this chapter, one-to-one GP supervision is compared in turn with group-supervision, with peer groups, and with personal psychotherapy. Some of these GPs had also had experience of multi-disciplinary groups and of group-psychotherapy, but these are mentioned only in passing. This chapter firstly outlines the interview data relative to some of these activities. The following discussion identifies the various roles of the supervisor, and the points of focus within the supervisory process. These lead to a working definition of supervision in general practice.

9.1 One-to-one supervision versus group supervision

Group supervision is similar to one-to-one supervision in terms of providing a forum for GPs to discuss their work. In group supervision however, the focus is more often on their patients, rather than on their professional development. Groups allow GPs to see how others cope with similar patients, but they can increase individual vulnerability, as presenting one's patients always involves some degree of presentation of oneself. The advantage of group-work is that it is cheaper.

Wendy initiated her involvement with supervision in a group of four GPs (and one supervisor), but then moved to shared supervision with one other GP. In this discussion she revealed why there are often some vulnerabilities in group supervision.

What's the difference between having group supervision, and one to one?
Wendy: Um, well, as I say, I've never had total one to one, because I get shared supervision. Although often, one or other of us will be away, and so I have reasonably up-and-going just one to one.
(Compared then, to the larger group?)
The group process tended to take over at times... I got frustrated with the group process, and because it was a group of four people who came from quite radically viewpoints, that was interesting initially, but...some of the
others, wouldn’t go to the level that I was prepared to, in terms of challenge, or looking at things in a very intimate, informal way, but I was ready to do that, and the rest of the group weren’t prepared to go to that level. So the group was disbanded at that point. I certainly preferred the supervision I went into subsequently, with one other person, whose ideas and level of operating, and world view, was pretty compatible with my own. I felt I got more out of it, that we weren’t going around in circles as much...

**Following on, the group process interfered with the purpose of the group, to some extent?**

Wendy: Yeah, to some extent. The group dynamics meant that it wasn’t necessarily a safe space that people in the group could say what they really wanted to say, that they were constantly watching out for what the other people thought they said.

Her subsequent analysis of that group illustrated her understanding of quite complex dynamics.

_Some of the group dynamics were quite complicated, and were very transferential, and my transference with (him) was quite deep and positive, and inappropriate in the way that I felt quite caught up on him as a masculine figure, as perhaps a benign father figure - I don’t know - But found it quite difficult to be objective, and this was just part of what was happening in the group, because one of the other group members had developed an opposite transference - he was a ‘negative, authoritarian male figure’, and we never stayed together long enough to find out what the two others thought._ [Laughter]

**Fascinating.**

_It just wasn’t a very healthy set-up, because the roles had developed gradually over time, without ever being properly addressed._

In terms of resolution of conflict the option was to disband the group, rather than becoming explicit about roles, transference, interpersonal group process and so on. Given that their purpose was to review their management of certain patients, it would have taken considerable effort from all involved to alter the emphasis toward an experiential interactive group and so disbanding should not be viewed too critically. Similarly, group supervision could be seen as an initial step toward the more challenging one-to-one supervision where perhaps an even deeper level of personal intimacy is required and “hiding” in a group would not be possible.

David was in a different group, but he also had problems (as mentioned in the previous section).
David: There were times when it was pretty difficult. On one particular occasion...I got a real dressing down from somebody, and that related to their own issues, and we're now quite friendly, and [laughter] you know... Well, it is a vulnerable situation, and there is an element of risk and sometimes, when other people are being vulnerable too, there may be, um... Well, the stakes are higher and so if somebody doesn't react to you in an appropriate way, or, their own issues are getting in the way, then there is the possibility of some heat and conflict. I think that has to be, in group supervision anyway, the more vulnerable it gets, the stakes are higher, the rewards are much higher, but there is to some degree a price to pay perhaps. I mean, those sorts of things happen on odd occasions, but they were only odd occasions.

Despite that, David found it a very valuable learning experience. I asked him what they actually did in his group.

And that was presenting patients, especially difficult situations, looking at how we might deal with some of the counselling, or some of the emotional issues related to it, and lots of role plays, which were actually very valuable, very valuable with a supervisor giving you some options, and advice at various points...

So can you tease out a bit further the feeling in the group that was useful? David: I think it was seeing how other people deal with situations, and you compare the way you would deal with it. The role playing, when you have another doctor role-playing a patient, I think it felt a bit more true often, to how it actually is in the practice, maybe, than when the therapist role-plays the patient. The GP just sort of knows the situation a bit better.

David eventually moved on to one-to-one supervision, but despite his reservations above felt the group work provided something that his later supervision did not.

And, [pause] I have this feeling about that which is quite hard to articulate. I think, just one to one supervision actually, wasn't as good as one to, maybe, a couple of doctors with a supervisor... we had four doctors with a supervisor. The larger number actually provided something that the one to one didn't. I think the one-to-one does provide something else, but that small group was...very worthwhile actually, in sharing their own cases, even though I wasn't doing it every week.

However he eventually wanted to try a one-to-one set up.

So, after a while I came to the view that I might get more out of this if I could present my own case every week, rather than once every three or four, but actually I lost something in that. I thought that was going to be of more value than actually it turned out to be. This was in significant part due to the (first) supervisor.
David also explored “action-methods” as another form of professional support, and realised just how far he had come.

David: I was involved with this other supervision group...with doctors, using action methods, and I found that it wasn’t actually that worthwhile because it was a bit too safe. It was more problems ‘out there’, rather than the doctors dealing with his or her own issues in relationship to their patients, and it was an interesting measurement for me, seeing, actually, how far I’d come over the last few years. So it was quite interesting to get some measurement, or some reflection back, of where I’d come. And I found that most of the problems that were being talked about, weren’t really too much of an issue to me.

In summary so far, group supervision was cheaper and had the advantages of seeing how other GPs function in their work. However, the leader needed to be quite skilled to cope with the inevitable emerging group process and unless this was an explicit contract in the beginning, the implicit tensions in the group could interfere with the learning.

9.2 One-to-one supervision compared to work in a peer group

As noted, most GPs in New Zealand are now in a peer group, although there are logistical difficulties in rural areas. Peer groups provide GPs with collegial and technical support. Supervision seemed to provide more specific interpersonal support for difficult patients, for learning how to do counselling, for discussing their philosophy of practice, and for certain specific situations. Lee explained how peer groups have a different purpose and style of function.

What’s it been like in the peer group?
Lee: Well, variable. [Laughter]. I’ve been in a peer group with the same people over about – it must be – eight years or so...And with that I’ve had the same difficulties in terms of presenting stuff in that group, as I’ve had in my Balint group, but I suppose it’s more, yeah, well, it was more physical medicine orientated than the Balint style, which was doctor-patient orientated. As you’ve got to know your peer group over the years, has that eased off, those difficulties?
Lee: Um, yeah, yeah, it’s a lot better. And as I’ve developed a bit too.
So can you compare supervision with your peer group then?
It’s a good peer group – I don’t want to undermine the peer group, but it’s not the same as supervision.
It has a different purpose.
Yeah, to me, the peer group – I keep up with, um, the medical scene, and sort of, current practice really, and so I feel I can touch with that. And I think we do know each other well, and we do support each other, and people can
discuss difficult cases that they feel bad about, in that sense it's quite a supportive group. But it, um [pause], to me it's really been more, sort of, something that I've done in order to make sure I'm in touch, rather than something that supports me. I've got my support from my supervision. It's been more of a stress for me than a support, but it's been something that I've felt I needed to do..., because I need to keep in touch with medical scene.

Robyn also used a peer group and personal supervision and cryptically pointed out one of the differences between these two forms of professional support.

So, (the supervisor) looks at how you're practising, in respect of your views and philosophies of practice?
Robyn: So, it's a forum that I can discuss that in...
You don't have that somewhere else? Like in a peer group?
Robyn: Oh God, my peer group, we wouldn't talk like that.
What's the difference between a peer group and supervision?
Robyn: I'm honest in supervision [laughter].
Well, in my peer group – I'm not very comfortable with the people in the peer group. We're so diverse that I'm not very comfortable expressing my real opinions on what I would like to do, or what I think about this situation, and so it stays very mechanistic... with my general practice peer group there isn't room to admit, um, weakness.
(Also) if I told them about my philosophy, and vision in practice of medicine – they'd just have no idea about what I was talking about.
You mean about your boundaries, and respect for patients?
Robyn: Yeah, and my sort of, sense of self-esteem in what I'm doing now, and the fact that I have confidence in what I'm doing, and I have vision that there are special things that I can do with my growing skills, and things like that; and they just don't relate to that at all.

Using the difficult patient as an example, David compared the peer group with one-to-one supervision. His point was that there is more of a technical focus in the peer group ("Oh, you can use this drug for that"), but he found it less useful for dealing with the difficult patient than a counselling approach. His specific example illustrated this.

Is it worth giving another example? Another one is an extreme somatiser who is a sixteen year old girl who is extremely difficult to deal with, who tries to control me at every point, won't allow me really to be her GP – comes with a general practice problem, but won't allow me to be her GP, and it's very, very difficult.
She gets angry with me, I get angry with her, she's rude to me. And, so, I have, and will again, discuss that with her. It would be fairly pointless discussing that in my peer group, it just wouldn't get anywhere, and typically this patient, you know, will go and see another GP when she gets angry with me...
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Paul had a peer group too.

*Going back to the peer group then. What’s the difference between peer group and supervision?*

Paul: It’s more mutual support, I think. (Pause) And it may be tied up with, I guess...you might be discussing frustration and things with ACC, or bla, bla, bla, that sort of stuff. And that can be quite supportive, and you may be helping another colleague to work their way through some amazing situation, which they may present, something which may be to do with their work... the CHE are thumping on them more, they need some way, some support to get through that.

Now they could get that, I guess in their own supervision, if they have it. But a lot of those people don’t actually have their own supervision.

Paul has raised an important issue here that the peer group acts like supervision in some ways. However, all of these GPs mentioned that they get less out of presenting the difficult patient to their peer group than to their supervisor, as there is more in-depth emotional and psychological work in supervision.

In the focus group the topic of “co-mentoring” was raised, in which two close colleagues meet on a regular basis to mentor each other. Robyn questioned the value of that, however.

*What are other people’s view on that?*

F/Robyn: Can I throw in two things there. I’ve seen that co-mentoring project idea and I thought, and also in answer to this ‘should supervisors be psychotherapists rather than doctors’, one of the things that I find incredibly valuable about my supervision process, is that my supervisor can look into the little tricks I’m using in dealing with my life, and go ‘Ho, ho, ho, look what you’re doing here’. Which is because of his psychotherapy skills, and in that co-mentoring process I think that would get lost.

Mark: Yes.

Robyn: You know and that you wouldn’t get that bit.... And for me that’s probably the most valuable part of the supervision. That looking into what I’m doing that’s come from coming from my own process, which is impacting back on the way I am in my office. If the truly valuable part of the supervision process, or the supervision itself, and therefore in that co-mentoring thing, you’d lose that idea.

So in answer to that question that should supervisors be psychotherapists rather than doctors, um, I don’t think they have to be psychotherapists, but I think that they have to have a good grounding in psychotherapy skills, in order to be able to do that ‘ho, ho, ho’...

Yes, so as (he) says you want them to be psychotherapeutically based and my addition is that they have to have some sort of functional difference as well.

Yes (coming from everyone)
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This concept of “functional difference”, which was supported but not discussed explicitly here in the focus group, was further explored in the section on the doctor-supervisor relationship in the last chapter.

Both Mark and Wendy used to be in Balint groups as well, so this particular group of GPs had covered almost the entire range of professional support systems. Wendy provided a summary of her experience, which concludes this section on the difference to peer groups, and leads into the next section on personal psychotherapy.

Could you rank it in terms of importance? Supervision, personal psychotherapy, Balint group, peer group – in terms of your development as a doctor?

Wendy: Um, okay. If I had to put – at the bottom of the list, I’d put the peer group, because it tends to be, I’ve only been in this peer group recently, but the ones that I have been in, in my GP training – the dynamics were reasonably superficial. Balint group, I find very helpful, and it’s appropriate to my stage of development, and intermittently it was great, but I found it frustrating, so I’ll put that for number three. Um, probably, in terms of my work, professional supervision would come at the top, but it would be very closely followed by personal psychotherapy.

9.3 Supervision compared with personal psychotherapy

From these GP’s reports, it seemed that personal psychotherapy can also help GPs in their work, by increasing their awareness of self in the doctor-patient relationship. This is a relatively new concept in the history of medicine. Prior to Balint’s work in the 1950’s, the doctor was required to have no self, as the mode was one of personal detachment. Clinical objectivity was taken to an extreme, at least in theory. Balint’s contribution was to legitimise the doctor-patient relationship as a valid point of reference (Balint, 1957), and this inevitably meant that the persona of the doctor became relevant to clinical practice. The focus in supervision is on work and professional life, compared to personal psychotherapy where the focus is on self. However, there are some inevitable areas of overlap, which this section attempts to define.

As noted before, one of the barriers to supervision is the idea that it could become personally threatening, or move into personal therapy without that being the intention of the GP. These doctors were very open about these issues. Some had had personal
therapy in other contexts, and so were articulate about the differences. Wendy had this to say, for example.

There have been times when my supervisor has said ‘this is a personal psychotherapy issue, I suggest you take it to therapy’, and trying to draw a boundary, and draw a distinction between supervision and therapy, that’s very important. And I suspect some people don’t understand that, and don’t feel comfortable with it – that they think they would be baring themselves in supervision, and that isn’t necessarily how it is. In fact, if they start stripping off, and baring their souls metaphorically, they’ll probably be told to take it somewhere else.

That’s from your experience, is it?
Wendy: That was my experience, but that also may reflect the style of my supervisor. Both supervisors. (The first one) was pretty staunch about that, as well – that some things were appropriate for the group, and some things you should take away, and work on somewhere else, in a different way. And I feel pretty clear about the difference.

Mark had a different experience of supervision, where the supervisor allowed the session to move into more personal work. He explained in detail how this is dealt with.

Mark: And to be quite honest, a lot of sessions I’ve had with all three of my former supervisors, have moved into personal stuff as well, and it gets dealt with. Although (my first supervisor) was the only person who said specifically now, ‘these sessions are supervision, they’re not therapy’, I’m sure we drifted over that boundary several times.

How do you differentiate?
Mark: [pause] Um, I think it’s quite difficult, because supervision, I believe the substrate is client based, and my interaction with that client, relationship issues with a client and so on... I think, it becomes more inter-personal psychotherapy when I come along and say ‘look, I want to talk about how I’m feeling in my world’. And, why things stuff-up. I’m not bringing a client today; I’m bringing me.

So that’s start at the beginning of a session. Would not that arise through the work with your clients sometimes?
Mark: Inevitably, it’s fundamental that my understanding of supervision, very rapidly moves to, not so much what’s wrong with my client, or why is my client difficult, but what is it about me that makes this client difficult to me. And, so inevitably, I think client-based supervision, has to drift – well, I want it to drift for me – into ‘what is it about me, that makes this work, or makes this not work’, and if that’s what it is about me, do you understand where that comes from, and the processes that make you where you are, which I regard as being fundamental to personal psychotherapy.

Right, so, it’s very hard to differentiate then? It’s very hard to keep them separate?
Mark: Yes. Well, I don’t think it necessarily should be separate.
Although on occasions, you might go off and say 'well, there's a personal issue and I want to spend some time on it'. The way I see it, is you're talking about a relationship that has two people in it, and inevitably you'll talk about how you bring yourself to the relationship. But that's not psychotherapy.

Mark: That's not formal psychotherapy. There have been occasions when there hasn't been another relationship – it's been a 'me' issue, and [pause], a certain need to look at the 'me' issue. Maybe that could be interpreted as an abuse of supervision, but, I believe that if my supervisor is happy to engage in that way, I mean, he could've said 'now hang on a moment, this isn't therapy – it's supervision, if we're going to do supervision, I need you to bring cases'. But, he has never done that, I mean, he's been very happy to look at me. So, you might say that he's allowed our sessions to be, variably, supervision or personal therapy. And if that was my need at the time, and he's not going to put limits on it and say 'no, no, stop, and stick to one substrate....', I think that's maybe tacit, but clear.

This complex discussion seemed to resolve the either/or issues between supervision and psychotherapy. As Mark has indicated above, it may be hard to differentiate between the two, as process-orientated supervision is designed to move into why that particular doctor has difficulties with certain patients. All these GPs were quite clear that they wanted that sort of supervision, rather than an exclusive focus on the patient's medical details. John was quite clear about this.

Of course they overlap, if they don't overlap then supervision is useless, because it means you're not dealing with any of the stuff that's personal to you, that's your own particular quirk that is influencing things.

This was also borne out in Paul's interview.

I mean, does supervision inevitably turn into personal psychotherapy in some sense?

I think, yeah, there has to be some personal psychotherapy in it because that relates to how you work. And if we think about the 'shoulds' thing, there will be issues come up at work, and then if the person who you are seeing has got to know you, they'll say; "you're just starting to do... the old 'shoulds' are coming back in again, and we'd sort of decided that probably you should be, ought to be saying 'no' to those sorts of things".

So, yeah inevitably I think there must be something to do with how you're managing yourself, which relates to your work. I think it is a very difficult... I mean I don't think supervision can be separated from personal issues in a sense. And I think it does keep you, does keep you safe because there's no way that a doc, when you work, you take all this stuff that's running around in your head to work with you.
And I think, if with help you are able to get that in perspective, it makes work safer and easier and everything else as well... I mean, I find it very difficult to actually separate off...

The following example illustrated that the “self” of the doctor can be intrinsically involved in the doctor-patient relationship.

Paul: But the transference, and all that sort of stuff, where you actually start picking up on the feelings of... Yeah. I mean, you might finish up being that kids ‘father’. But you have to learn, you have to know, you have to be very clear and accurate about what you’re going to do about that. That feeling; I mean you can’t go literally stand up and put your arms around the kid. That’s not appropriate. You might have to put your hands in your pocket.

I’ve written a lot of poetry about this sort of stuff. That (gift over there) was given to me by a student who had lots of abuse, and stuff, and had all sorts of problems. And she came to me saying she was going, and I’ve written a poem about it that, when I, you know there was this great poignant moment when she’s going to go, and you realise that she’s walking out of your life, you’ve been actually involved with (her) for seven years. There’s a sense in which you could just hold onto her, but in actual fact it’s inappropriate because you’ve been a model for her, in terms of what a male can be in someone’s life, and you’re not going to take advantage of that relationship.

So it’s very much, ‘well, all the best, look after yourself’ And that is incredibly important. So there’s a point at which yeah, there is this feeling stuff. But there’s also a point at which you actually have to be, almost observe the feeling stuff, so you don’t do the wrong, so you do the appropriate thing.

This was quite a complex illustration of the interplay between detachment and involvement. Clearly, Paul had been very involved with that patient, but his ability to keep a track on the transference (from a judicious use of detachment) enabled him to negotiate a delicate and important ending to the therapeutic relationship.

John found that certain experiences with patients triggered a need to do some personal psychotherapy independent of his supervision.

Well, the supervisor that made it clear to me that she saw that there was a distinction between issues that were coming up... that were interfering with my work... I suppose and that’s sure, there is some overlap, but that she reserved the right to say that ‘look that’s some stuff you’ve got to deal with your personal counsellor this isn’t supervisory stuff’.

David’s experience of a personal psychotherapy group illustrated how that can be of considerable benefit to work in general practice.
And I think, you can only know somebody else to the depth that you know yourself, and whenever that increases with the doctor, his or her capacity to [pause] be open to, comfortable with, free with other people, is greater. Less of your own stuff gets in the way. To put it another way, there’s plenty of discussion at times about ‘the difficult patient’ but not nearly enough about ‘the difficult doctor’ that’s in each of us.

(In the) personal growth group... I actually got... a new sense of my ‘okay-ness’, it sunk down to a deeper level.

And, in fact, my involvement with that group, which was for six weeks, two nights a week, two hours a night, has actually affected my relationships with my patients much more than the earlier supervision group, that was much safer, and didn’t deal with the doctors personally. It was dealing with the patient’s problem, and not acknowledging the part that the doctor actually plays in interacting with that, and so I found as a result of the personal growth group, that I found myself feeling more open with some of my patients, more relaxed with them, more comfortable with them.

The result was that David became more aware of himself and his relationship with his patients.

So you’ve become interpersonally aware, is that right?

David: Absolutely, I think that’s the other thing about the counselling and psychotherapy, for me it has also very much been a personal journey, and my awareness of the issues of my patients increases my awareness of myself. And I’m totally convinced about the... if you’re going to do counselling or psychotherapy, you need to have some yourself, and having done that, my own level of self-awareness is much greater, and my ability to be aware of my patients is also much greater.

Supervision can highlight areas I need to deal with in myself, but doesn’t spend time on those areas. I would need to sort it out myself or seek specific psychotherapy for them.

If you were to go for psychotherapy yourself, would you go to the same supervisor?

David: No, I wouldn’t no, definitely not.

You’d separate it off.

David: Definitely. Yeah.

So there was a difference in experience here between these GPs. Some discussed their own issues with their supervisor, while others made a separate arrangement. All were aware of the overlap between personal psychotherapy and supervision and the arbitrary line that is sometimes made between these two forms of professional support. Here is the final word on this from Wendy.

So could you clarify for me the difference between psychotherapy and supervision?
Wendy: *I don't think you should go to supervision to deal with the issues you have with your mother, or the issues that you have with your partner, or even though, some of the conflicts, or underlying messy stuff will affect how you work as a doctor – it's not the forum for that kind of work. You may learn things in supervision which are useful to that, like a certain patient reminds you of a teacher you hated at school, or a friend who’s always letting you down, or - the psychological context is obviously what's important, if you wanted to go away and then work on the relationship with the friend, you could probably do it in another way. That supervision focuses on how it affects you with your patient.*

To summarise the quotes in this chapter, supervision was not the same as personal psychotherapy, although the latter could also be helpful for GPs in their work. Supervision was different to work in a peer group although difficult patients and difficulties in one’s work could be dealt with (at least to some extent) in both of those contexts. One-to-one supervision was different to group supervision and some of these GPs started with group work before they move into a one-to-one professional relationship. These GPs found that the distinctions between professional and personal issues were necessarily blurred, as in their view, the self of the doctor was intrinsically bound up in the doctor-patient relationship. That being the case, it is logical that personal therapy would impact favourably on their work as a helping professional, and some respondents reported this to be the case.

Defining GP supervision is not easy, as there are considerable conceptual difficulties in the way, some of which are linked to the barriers preventing further uptake of supervision in the GP community. Other professional groups have integrated supervision into their mode of practice as a matter of course (marriage guidance, psychotherapy) but the culture of medicine is still a long way from such an idea. Historically, it is easy to see why this is so. Medicine's epistemological base has been that of the scientific method, with all the inherent injunctions of objectivity, detachment, nomothetic truths and so on. These concepts have tended to negate any idea of self or relationship and so work on oneself has not been a legitimate part of practice. Balint’s seminal work has initiated some counter-currents to those notions, with these GPs being prepared to go to considerable lengths to increase their self-awareness. This includes their work in supervision as well as in their other forms of professional and personal development. Their frank disclosures in this study illustrate just how far they have already pushed the boundaries of established practice.
CHAPTER 9: Defining supervision in general practice

The following section further defines supervision as part of professional maintenance, and then there is a summary of all of the data from the five chapters of results. After that, GP supervision is analysed in generic terms, including consideration of the points of focus in supervision and the roles of the supervisor. At the end of this chapter is a definition of supervision in general practice in New Zealand.

9.4 Supervision as part of professional maintenance

Figure 9.1 illustrates the inter-relationships between various forms of professional support. At the top of the diagram, note that practitioners do receive considerable support from their friends and family, and these need to be distinguished from the professional activities listed here. The main forms of professional help are usually either about content (technical advice and diagnosis and treatment) or about one’s interpersonal issues with patients, staff or other members of the therapeutic community; in other words the process of one’s work. Once again, this can be done in an unstructured or structured way, using either one-to-one methods or in groups. Peer groups in New Zealand are usually limited to GPs only (hence are intra-professional), and from the experience of the GPs in this study, peer groups have a legitimate focus on both content and process.

The methods discussed in the results above (peer groups, GP supervision, personal psychotherapy, Balint groups) are listed in bold in the diagram. Balint groups can be both inter-as well intra-professional. GP supervision and personal psychotherapy are both forms of one to one development (Figure 9.1).
Figure 9.1 Professional Support Systems

Professional Support Systems

- Personal (family, friends etc)
- Technical/material/content
- CME
- Peer groups
  - Balint groups
- Professional
  - Interprofessional processes/relationships
    - Structured
    - Unstructured
- Interpersonal processes/relationships
- Group work
  - One to one
  - GP supervision
  - Personal psychotherapy
  - Inter-professional (cross-professional group work)
9.5 Summary of the four chapters of results

These results have been based around the recorded quotes of the participants from the research interviews and from the research focus group. There have been four major themes:

- Dissonance and Tension
- Self-awareness and Professional Development
- The Supervised Practice
- Defining GP Supervision

An overview of main findings of this study is as follows.

**Dissonance and Tension**

These GPs had both general and specific learning needs. They needed back-up for their counselling and psychotherapy skills, especially when taking patients for formal hour-long counselling sessions. They also used the supervisory system as a sounding board to review the cumulative effects of professional life, some specific difficulties of professional practice, practice management, and relationships with peers. They received validation about their work skills and philosophy of practice, despite any feelings of being different to their peers. These GPs had to work through some significant cultural barriers before they could receive the benefits of having supervision, and they chose and changed their supervisors depending on their specific needs at the time. The supervisor needed to have psychotherapeutic skills, but could be a psychotherapist or a doctor. Once these barriers were overcome, these GPs 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**

Supervision helped GPs become more self-aware of their own issues, and of the minute to minute issues in a consultation. These GPs wanted to be challenged and criticised in a safe environment in order to grow and develop in their professional role. Most of them were not supervising other GPs, but did consider that they may eventually do so.
CHAPTER 9: Defining supervision in general practice

The Supervised Practice
There was considerable variation in how these GPs set up their practice to reflect their counselling and consulting interests. They 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 ordinary patients as they could recognise and deal with the emotional factors in other 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, and had a method for working through any relationship difficulties. They considered that they facilitate “healing” or recovery of their patients through their interpersonal relationship, and some believed that they dealt with the suffering of others better, if they had a sense of their own suffering or woundedness. 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. They used supervision to not only review their patients, but also as a place of dedicated reflective time. Learning was self-directed from their needs and from their experience. They worked hard to clarify the boundaries around their role as GPs.

Defining GP Supervision
One-to-one supervision was different to group supervision, to work in peer groups and to personal psychotherapy. Group supervision was cheaper, allowing GPs to see how others coped with similar patients, but group work can increase 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. However, there were some areas of overlap. Personal psychotherapy could also help GPs in their work by increasing their awareness of self in the doctor-patient relationship.
CHAPTER 9: Defining supervision in general practice

9.6 The system of medical supervision

The next few sections analyse how supervision works in the service of the GP, by detailing the process of supervision, the focus points of the supervisor and the supervisor's roles. These are outlined in generic form, which serve to clarify the process of supervision in general practice.

Putting it as simply as possible, the patient consults with his/her doctor, and then the doctor discusses that patient with the supervisor. However, because both the patient and the doctor are seen in their wider social contexts, the state of the doctor's professional development is also relevant to the discussion of each patient. This seems to be the basis of the supervisory process in general practice (Figure 9.2).

Figure 9.2 The medical and the supervisory systems

[Diagram showing the medical system, the supervisory system, and the relationship between doctor, patient, and supervisor.]

Adapted from Williams (1995)
9.7 Focus points in the supervisory system

From the evidence of this research, it is possible to identify six points in the supervisory system between patient, doctor and supervisor, that the supervisor was focusing on. For example in Chapter 6, one topic was counselling back-up. The supervisor’s focus there would be on the details of the patient and the doctor’s medical and psychological interventions (focus points 1 and 2). By contrast, the supervisor’s focus when the GP is discussing practice management, peer relationships, or seeking validation about their work, is more on the functional “state” of the doctor as a health professional (focus point 4). When the GP chooses or changes the supervisor, the focus is the relationship between the doctor and supervisor (focus point 5). The whole range of focus points is outlined in Figure 9.3.

Figure 9.3 The six foci in general practice supervision

1. The patient’s medical state and his/her experience of illness, as narrated by the doctor
2. The doctor’s medical and counselling activities
3. Doctor - patient relationship, as experienced by the doctor
4. The doctor’s functional state, including “state” of professional development
5. The supervision process between supervisor and doctor
6. The supervisor’s activities and experience
CHAPTER 9: Defining supervision in general practice

With reference to the diagram, there are two interlocking systems; the medical system of patient and doctor, and the supervisory system of doctor and supervisor. These foci are outlined further in Table 9.1.

Table 9.1 Focus points in supervision

The medical system
1. The patient’s medical state and his/her illness experiences, as narrated by the doctor, with the focus on the patient.
2. The doctor’s medical and counselling activities: what the doctor did with and for the patient; theory, practice and treatment. The focus is on the doctor.
3. Doctor-patient relationship, exploring the interaction between the patient and doctor, and the dynamics of their relationship. The focus is on the patient and doctor.

The supervisory system
4. The doctor’s functional state. Here the supervisor focuses on the immediate state of the doctor in the supervision session. This would include his/her emotional state, as well as the state of his or her professional development. The focus is still with the doctor.
5. The supervision process between supervisor and doctor: what goes on between doctor and supervisor, including the possibility of “parallel process”. This is where issues or problems in the doctor-patient relationship are sometimes enacted out subconsciously between the doctor and supervisor. The focus is on the supervisor and the doctor.
6. The supervisor’s experience: here the supervisor brings his or her own immediate feelings or hunches into conscious awareness, sometimes unlocking unexpressed parts of the doctor’s narrative or doctor’s state. The focus is now on the supervisor.

Adapted from Williams (1995).
9.8 The roles of the supervisor

As listed above, there are six points of focus within the medical and supervisory systems. To be able to attend to these different foci, the supervisor needs a range of flexible roles. The four main inter-related roles of the supervisor in GP supervision appear to be those of teacher, facilitator, analyst, and evaluator. To be a teacher, the supervisor needs good theoretical and practical understanding of the principles of psychotherapy. In general practice supervision, the supervisor also teaches various counselling approaches to the difficult patient, even though there may be no diagnosable psychiatric disorder present.

As the focus widens to include professional development, the supervisor is more in the roles of facilitator and analyst. As facilitator, the supervisors in this research provided a forum for professional concerns, respected the GPs’ beliefs, and provided opportunities for expression of feelings. As analyst, they provided options rather than answers, and were aware of the context of general practice and the unique pressures on today’s GPs. Their focus was more on the doctor requiring change to cope with various situations, rather than the “difficult” patient requiring changing.

In general, an evaluator role is necessary in all teacher-pupil relationships. The supervisors here were constantly evaluating the GP’s performance, giving feedback and re-evaluating the GP’s original goals and purpose. There was no summative evaluation role noted in this study (for example, admission to various professional bodies or colleges on the basis of supervised work activities). Table 9.2 (next page) summarises the four roles of the supervisor in general practice supervision.
Table 9.2 Features of the four roles of the supervisor in GP supervision

**Supervisor as Teacher**
- Comments and instructs on the patient presented.
- Suggests or models interventions.
- Sets readings on certain topics.
- Establishes clear goals for further work.
- Has well-developed theoretical base and teaches about this.
- Questions rationale and theoretical construct of the doctor.
- Comments on doctor's skills, knowledge and attitudes.
- Observes doctor in his or her work, either directly, by transcript, by audiotape or videotape, or (most usually) by self-report.
- Recognises professional developmental stage of the doctor.
- Encourages adult learning.

**Supervisor as Facilitator**
- Respects doctor's beliefs and meanings.
- Provides opportunity for doctor to express and process feelings about patients.
- Models relationship skills.
- Builds trust.
- Gives of him or herself.
- Provides a forum to discuss workplace difficulties or concerns with professional organisations, or philosophy of practice.

**Supervisor as Analyst**
- Provides options rather than answers.
- Experiments with different ways of assessment and intervention.
- Collaborates with doctor to work out problems.
- Intervenes with doctor at the strategic rather than simple teaching level.
- Observes activities of doctor as potentially furthering a dysfunctional system.
- Attends to doctor-patient system.
- Is aware of own role in the system of doctor-patient-supervisor.
- Is aware of outside influences on doctor and supervisor.
- Focuses on doctor requiring to change, rather than on the “difficult patient” being required to change.

**Supervisor as Evaluator**
- Re-evaluates original goals or needs of doctor.
- Checks that the doctor has implemented previously discussed strategies or ideas.
- Gives feedback to doctor on work performance, knowledge of theory and personal qualities.
- Helps doctor evaluate his or her own strengths and weaknesses.

(Adapted from Williams, 1995.)
9.9 Defining GP supervision

This chapter has presented considerable data that help to define supervision in general practice. GP supervision is one of a number of professional development activities; it needs to be distinguished from other work in continuing medical education, peer groups, or personal psychotherapy. The results of this study suggest that these GPs use a model of supervision very similar to that described in generic form in Chapter 2. This is not surprising, given that the supervisors were largely chosen from fields in which the concept is already well developed and that a large part of the GPs' motivation here was to learn how to do psychotherapy. What this implies as well though, is that GPs are no different to other helping professionals in requiring a safe and dedicated forum to discuss their work. The following paragraph is a brief summary of GP supervision.

**Summary of supervision in general practice**

General practice supervision is a powerful method of professional maintenance and development. It is different to peer-group work and 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. By holding and validating the GP in his or her work, the supervisor provides a safe place for professional reflection and challenge. 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.

Throughout these results, it has been assumed that the method of research (qualitative interviews) has produced findings that are valid. The next chapter on validity discusses these issues in considerable detail, which then allows the implications of the findings to proceed in Chapter 11.
CHAPTER 10: Validity and transferability

10.1 Introduction
How valid are the findings of the last four chapters? Does the measure I have used (interviews) give an adequate representation of the experiences of these GPs? Can these findings (or “truth”) be generalised or transferred to other settings, or are they just relevant to the participants in this study? While Chapter 4 was more concerned with the reliability of the data analysis, that chapter did to some extent, assume that the data collected was an accurate or “true” account of the phenomenon under study. In other words, were the interviews authentic? Some of the validation points in Chapter 4 (points 1, 2 and 4) indicated that the participants were comfortable with the content of their interviews (as giving a reasonably accurate representation of their experiences), but there are further conceptual issues that need to be reviewed before the findings can be considered valid. It is only after those considerations that the implications of this research can be advanced.

Firstly, this chapter introduces the concept of findings as being a “socially constructed process”. Features that contributed to this construction were the quality of interviewing, issues in the interviewer-interviewee relationship and considerations of power. This leads to an analysis of how “bias” in this research has influenced the findings. The nature of truth can then be considered. The notion of transferability (of such truth) is posited, whereby different readers may interpret the results in a number of ways. Finally, it becomes apparent that this research is a worked example of a social constructivist paradigm that was presented in Chapter 3.

10.2 Interviewing: issues of quality
Having experience of general practice could imply that one already has interview skills (Murphy and Mattson, 1992). This thinking however, is rather naïve, as there are unique issues in the interviewer-interviewee relationship that require critical examination. Kvale (1996) has written extensively on interview research and he listed six quality criteria for an interview. (Table 10.1)
Table 10.1 Quality Criteria for an Interview

- The extent of spontaneous, rich, specific and relevant answers from the interviewee.
- The shorter the interview’s questions and the longer the subjects’ answers, the better.
- The degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers.
- The ideal interview is to a large extent interpreted throughout the interview.
- The interviewer attempts to verify his or her interpretations of the subject’s answers in the course of the interview.
- The interview is “self-communicating” – it is a story contained in itself that hardly requires much extra descriptions and explanations.

(Kvale, 1996, page 145)

Kvale strongly recommended that “the interviewer knows what he or she is interviewing about” to achieve the last three criteria: “The meaning of what is said needs to be interpreted, verified, and communicated by the time the tape recorder is turned off” (Kvale, 1996, page 152). A naive interviewer with no experience in general practice or experience of supervision would have had considerable difficulty in interpreting and critically examining the topics raised by these subjects. The interviews in this research seemed to be full of rich and important data with very few instances of irrelevant chit-chat. This may have been due to the existing collegial and friendly relationship with some of the doctors, to the fact that these were extraordinarily articulate and philosophically aware subjects, and perhaps to the interview style, which I believe in retrospect, was respectful as well as probing.

10.3 The interviewer-interviewee relationship

The success or otherwise of this research was dependent on the researcher-interviewee relationship. In some ways this is a relatively novel statement, for while the purpose of ethical considerations and procedures is designed to keep participants in research safe (from harmful aspects of interviewing) the term “relationship” is rarely used. Terms such as intimacy, empathy, closeness, ambiguity, understanding, power, recognition, validation, or struggle, for example, are relatively absent in
medical literature, despite the likelihood that these issues may be present to some degree in every doctor-patient interaction. Similarly, these issues will be present in every interviewer-interviewee relationship as well. Perhaps the reason for this is the over-emphasis in modern medicine on structure and content, rather than on interpersonal processes.

The relationship between interviewer and interviewee is quite complex, and will inevitably influence the eventual data. As Scheurich asked: can we “illustrate, although never completely, the shifting openness within the interview itself….or highlight the indeterminacy of interview interactions in ways which allow for the uncontrollable play of power within the interaction?” (Scheurich, 1995, page 840)

I will now explore the issues of power, difference with therapy, and leading questions in my interview research.

10.4 Power in interview research

Until recently the notion of power has been conspicuously absent from medical research. Limerick et al (1996) explored the politics of interviewing in terms of the power-differential between interviewer and interviewee, terms which assume a passive role for the subjects of the research. While the Cartwright inquiry in New Zealand has turned informed consent and ethical approval into a necessary (if somewhat tedious) procedural hoop, it has not removed the inherent potential for interviewers to gain knowledge at the expense of their subjects’ feelings of autonomy, integrity, or locus of control.

(The method of interview-research) encompasses several assumptions, including a unidirectional flow of information from interviewee to interviewer, the sovereignty of objectivity, and the value of decontextualising and depersonalising the interview relationship...the complexities of the power dynamics that exist in research relationships should be acknowledged and discussed with reference to the actual research experience ...the discourse of power in the interviewing situation needs detailed analysis.” (Limerick et al, 1996, page 449).
Limerick et al. analysed their experiences of power relations in three research projects. Their analysis included: how contact was made with potential subjects, choice of location and time for the interview, the first fifteen minutes of interviewing where power and trust issues dominate the negotiations, acknowledging the agendas of those subjects who may have personal reasons for joining the research project, being responsive to interviewee changes in subject matter, and being aware of how interviewing can give subjects time and space to reflect on certain issues, yielding otherwise unexpected insights (page 450).

In the interviews for this thesis, I was acutely aware of the generosity of my subjects in giving their time for this project, their honesty and personal reflection in sharing, their commitment to often intense and detailed discussions on quite complex subjects, and their responsiveness to my probing. For example, it seemed to me that some had the potential to be supervisors themselves. This was pushed rather hard in one interview, yet it seemed to be taken without offence. In response to Limerick, I believe those issues were encompassed by my underlying research ethos being one of respectful enquiry. I agree entirely with their conclusion, however, that the interview is a "gift" from the subject to the interviewer. This re-framing of information-giving as a "gift" is reflected in the careful wording in my proposal letters, in the ethics and politics of the consent forms (see Appendices 1 and 2), and in the subsequent interviews where I felt privileged and even humbled sometimes by the power and authenticity of these doctors and of their stories and experience.

10.5 Differences between therapy and research interviews
Kvale (1995) usefully compared interviews in a research context to those in a therapeutic context. The goal in the former is the acquisition of knowledge, while the goal of therapy (or general practice consulting) may be a change in the patient. During interview research, a "quasi-therapeutic relationship may be promoted through long and in repeated interviews with the same subject, where a close personal rapport may develop, [which] may in some cases bring forth deeper personal and emotional issues requiring therapeutic assistance. Emotionally unstable subjects more or less consciously seeking the advice of a professional, may attempt to turn a research interview into personal therapy" (Kvale, 1995, page 155). Such an instance would be a boundary violation of the relationship between researcher and interviewee. This did
not seem to happen in my interviews despite the sensitive and potentially revealing nature of the conversations, although I was aware of an instance of a near "confessional" interview in a recent Otago study (Hall and Jones, 1999).

Kvale also discussed a potential conflict if the researcher is able to make interpretations that go beyond the self-understanding interviewees. “In therapy it may be unethical if the therapeutic opinion asked for [does] not lead to new insights or changes. In a research interview that the interviewee [has not initiated], it maybe unethical to instigate new self-interpretations or emotional changes” (page156). Part of my research method was to send back to the respondents a summary sheet of the issues they discussed, with a combined thematic analysis. Those summaries perhaps went further into the issues involved in supervision than their own individual formulations, and we discussed those broader issues in some depth in the focus group. However, those insights were not orientated towards personal growth or psychotherapy. Rather, they were clarification of theoretical assumptions about the nature of supervision. I believe then, that the boundary between the personal and the professional remained intact, even if as a result of my research, these subjects may have gained a deeper insight into their own reasons for using supervision.

10.6 Leading questions
Another problematical issue raised by Kvale was “leading questions”. I was conscious of this throughout my interviews and attempted to keep my questions as open as possible. The danger here is that such questions lead the interview towards certain preconceived conclusions, and this has been a criticism of qualitative research by those in a more objectivist paradigm. Yet Kvale was rather reassuring on this point. Part of a meticulous search for meaning could be the use of such questioning where it is warranted. However, it is possible that leading questions indicate the researcher’s underlying motives, or that the researcher was looking for a certain meanings; this leads to a consideration of the meaning of “bias”.

10.7 The contribution of “bias”
Interviewing as a research tool is inherently problematic. The purpose of interviewing is to produce a shared understanding of the topic at hand, and developing rapport between interviewer and interviewee facilitates this. However, there needs to
be a conscious tension between mutuality and the need for a degree of objectivity. Too much empathy and the interviewer could become unable to probe deeply where necessary. Too much distance or objectivity and the respondents could be less forthcoming. If the researcher was naïve about the field of study, the respondents may not go too deeply into the relevant issues.

In the case of this research, I am a working general practitioner and so shared common ground with all these GPs. This enabled us to go quite quickly to specific issues, rather than these GPs giving long explanations about the nature of their work. I have also had extensive experience of supervision myself in a number of contexts; this also avoided complex explanations by the respondents on the nature of supervision, and the respondents could talk openly without justification of their choice. Being aware of the tensions inherent in choosing to have supervision, I was also able to probe carefully on such topics as “barriers”, or “difference to psychotherapy”. Despite the interviewees knowing I received supervision, I did not however talk about my own supervisory experience in the face to face interviews. This was because I wanted to explore as much as possible their experience without my own views influencing the conversation.

In review, I used my own role as a GP to gain access to these participants, and then because the participants and I shared a common language and experience of supervision, we were able to go immediately to specific and complex issues. However, it was interesting to note that in the focus group at one point I consciously came out of the interviewer role to give my own view about the topic at hand; it was only at that point did I realise that my stance had been so self-effacing. We had been talking about these doctors becoming mentors to other GPs.

Robyn: And so that for me, that’s a huge barrier to becoming a mentor because if someone comes to me for mentoring, I think, I think about medicine in a very different way to a lot of other doctors... I wonder if I can just come out of my role as researcher here and give you my experience. I’m a supervisor for a junior GP in town, and I think (when) I started off as a mentor, we talked about content...

One could review these issues in terms of “objectivity versus subjectivity”, terms which perhaps hide the complexities of prior knowledge and shared understandings.
CHAPTER 10: Validity and transferability

However, while my chosen stance (a kind of objectivity) gave me a degree (or at least the illusion) of uninfluenced data, it also made one of the early interviews more stilted perhaps, than was necessary. The research supervisor noted how the tone of the interview changed after I had given this interviewee a compliment:

*One thing that I am picking up from this, is that you’re pretty psychologically aware, aren’t you?*

*Oh, it’s been running in my blood. So much so that I take it for granted, and this is why I was talking about...*

So mutuality here resulted in better rapport and eventually led to some complex and helpful disclosure by the end of the interview. Both being objective and being involved in the interviewing seemed to facilitate the generation of valuable and seemingly authentic data, and the tension is in being conscious of one’s state at any particular time. Judicious use of both states seemed to be required, with the outcome that much of the respondents’ words seemed to “ring true”. Nor did the respondents change their transcripts on review, although four of them added some further points.

“Bias” here seems far more complex an issue than just stating whether or not I have had experience of the issues in supervision. One overt bias is that I value the whole concept, which afforded me the energy and commitment to complete the study. Bias then, is a simplistic and almost pejorative term that belies its usefulness to the research process. Furthermore, if there was or is an element of unconscious or covert bias, I would be unable to declare it, yet it could influence the data. Having a hidden agenda would be disadvantageous. This would be a potential problem in all research, but in this case the initial interview with the research supervisor had the extra purpose (not apparent to me at the time) of eliciting any covert agendas which could then be discussed.

10.8 The creation of “findings”

These subtle issues are hidden within the eventual interaction and the evolving conversation between researcher and respondent, as shown in Figure 10.1 (next page). Note how the process of the research transmutes the ideas and experiences (of both interviewer and interviewee) into the only two pieces of hard copy; the
transcription(s) and the published thesis. All the contributing factors to those are however, complex social interactions.

**Figure 10.1 The social construction of findings**

Interviewee’s history and experience of certain topic

Selectively filtered points available for discussion

Complex interaction and conversation

Researcher’s knowledge, opinions and agendas about that topic

Research theory and assumptions

Mutuality versus objectivity

Variably shared understanding leading to a transcription of words

Researcher chooses data to discuss and present as findings

Published thesis

Reader

Reader (interprets according to own experience and background)
As indicated above (and being here the Devil's Advocate), the interviewee will selectively pick and choose which information he or she will present for discussion. The interaction will be variable depending on factors such as having similar backgrounds, training, and professional and personal interests (Oakley, 1986). As already noted in Chapter 4, the transcription process cannot hope to present a truly accurate account of a verbal interaction and much of the nuances of the discussion may be lost. The researcher will have conscious (and unconscious) reasons about which quotes to highlight at the expense of others and so the presented results may be rather idiosyncratic to that researcher. Finally, the readers will inevitably interpret the findings in the light of their expectations and past experiences.

This all sounds rather pessimistic; results may be seen as too subjective to be valid, and the researcher could be accused of "soft" research. Because such criticism is often levelled at research in the qualitative paradigm, the following sections are designed to counter those ideas and to show in fact that the findings can in fact, be transferred to other settings.

10.9 The validity of interview data

Once again, Kvale (1996) offered a resolution to these issues of validity.

(Criticism of leading questions in interview research) could stem from a naïve empiricism, (with a) belief in a neutral observational access to an objective social reality independent of the investigator, implying that the interviewer collects verbal responses like a botanist collects plants in nature, or a miner unearths precious buried metals. In an alternative view, which follows from a post-modern perspective on knowledge construction, the interview is a conversation in which the data arise in an inter-personal relationship, co-authored and co-produced by interviewer and interviewee. (Kvale, 1996, page 168).

Another writer who has contributed to these issues is Scheurich (1995).

In regard to interviewing, I take positivism to assume that the individual interview context (including for instance the personality or gender of the
interviewer) is not a critical consideration, and that a category-based reduction of the verbal text of the interview can be taken as a valid representation of the interview itself, and of the perceptions of the interviewee...Post-modernism, in contrast, suggests that there is a radical indeterminacy at the heart of interviewing interaction which can not be overcome by any methodology.” (Scheurich, 1995 p 250, emphasis added.)

These writers have suggested that there may be no single truth to emerge from interview data, and that the truths that do emerge are dependent on the interviewer and the interview process. In relation to these statements, my own position is that different interviewers or researchers would indeed look at supervision in different ways and do different interviews, but that there will be important messages to be gained from this particular research. Part of the rigour of this research has been to be explicit about the method used, the difficulties encountered and the underlying assumptions of the research paradigm. In this way, any criticisms of the results can be discussed within the context of this particular methodology (Mishler, 1986).

The apparent simplicity of “just doing interviews” belies their concealed complexity, and so the purpose of this extended discussion is two-fold. Firstly, I have endeavoured to show that the methodological decisions were not made randomly, but as part of the considered philosophy of relationship-based enquiry. Secondly, it is only through such a detailed examination of method that valid conclusions can be inferred from the results. Scheurich’s self-avowed post-modernism (“there is a radical indeterminacy at the heart of the interview interaction which can not be overcome by any methodology”) seems to almost negate any surety about validity. This view seems pessimistic. Having critically examined the inherent issues and difficulties of interviewing, I believe I am in a better position to assess its validity.

10.10 Generalisation versus transferability
The final published document will elicit different responses from different readers depending on their vantage point. In this way the outcome of this study shifts from the data listed as “Results”, to the possible effects on different readers. Perhaps the reader has some responsibility to interpret the findings in the light of his/her own
experience; this is what readers will be doing in any case. Some of the different
groups of readers could include:

- participants, who will review their own statements and the subsequent
conclusions. As Strauss and Corbin (1990) have said (as quoted in Cunningham,
1999); the discussion “should be more structured and self-consciously explanatory
than anything that the participants themselves would produce”, yet the
conclusions should “ring true” for the participants, whose overall response would
be a further measure of the validity of this research;
- other GPs who have supervision and who could identify with the experiences
listed;
- other GPs who are considering supervision and who could resonate with the
barriers to having it;
- those involved in counselling patients in general practice;
- supervisors of the GPs in this study, and supervisors of other GPs who could
review these reported experiences of GP supervisees;
- supervisors in other professions who are interested in the generic issues of
supervision;
- professional bodies such as Independent Practitioner Associations (IPAs), the
Medical Council or the Royal College; all have a vested interest in patient
outcomes, patient safety, and professionalism and personal health of practising
doctors;
- junior doctors considering general practice;
- those working through the issues of “General Oversight” where there is some
overlap with GP supervision;
- previous and prospective researchers in the field of supervision;
- theorists of medicine and of models of learning.

Rather than using the term “generalisation” to explain how these results would be
applicable to other settings, it is apparent from the list above that the applicability or
transferability of relevance and meanings will be reader-specific. This research was
not structured as a search for a universal or nomothetic truth, which would be
applicable across settings independent of context. “Truth” here is situational and contextural; “transferability” is a more appropriate term in this research paradigm than generalisability.

10.11 Validity in a social constructivist paradigm

There is now an emerging cadre of qualitative research within the Master of General Practice at Otago University, as well as in the wider medical community. Generally though, the discussion about validity or the underlying philosophical assumptions in interview data, has been superficial. What emerges from texts such as Kvale (1996), Maykut and Morehouse (1994), and Denzin and Lincoln (1994) for example, is the complexity of this type of enquiry and the need for a theoretical framework that is integrated throughout the methodology into results and discussion. “Theory enhanced” research as an idea, however, has only recently been discussed in the medical genre (Harding and Gallantly, 1998) with Varian (1998) and Carryer (1997) being recent examples in the interview-genre. Varian used a constructivist paradigm in her research on the experiences of women with the chronic disablement, as “the meaning of having rheumatoid arthritis would be different for each woman since she would interpret it in relation to her particular world. Each participant and the researcher were not expected to have the same reality of the world, but it was assumed that the interactions and interviews would give rise to changes in the perspectives of all people involved, giving rise to new realities” (Varian, 1998).

My own position (compared to Varian above) avoids any notion of absolute relativity (these doctors’ experience did in fact exist before I initiated this enquiry) and tends more to the middle ground. It would be difficult, if not impossible (given the limitations of language and the context of a certain way of knowing in a particular culture) to adequately interpret or express another’s experience, yet it is only through a shared exploration and construction of knowledge together that an intelligible version of that experience can be produced. Other words for this process could be synthesis or integration of knowledge. Such exploration could trigger the participants into reviewing their previous experience and could also mean their future experiences in supervision may be altered.
Similarly, compared to Carryer (1997) who used a feminist framework for her PhD research on the experience of nine respondents, this research was not intended to educate the subjects about supervision or emancipate them from cultural oppression. I have already outlined above how the respondents were affected and changed by the process of enquiry (at least, as far as they let me know), as an illustration of their involvement, but an “action-research” label here would be inaccurate.

I agree with Gergen (1995) in his rejection of modernism: “that the facts of the world are essentially there for study...existing independently of us observers, and if we are rational we will come to know the facts as they are” (page 91). “Rational”, here, seems to stem from a scientific rationalism and an uncritical adherence to an illusion of objectivity. The historical threads of this social constructivist philosophy include Berger and Luckman (1966), Goodman (1978), Gergen (1985), and Guba and Lincoln (1984) leading to the principal texts for this research in Maykut and Morehouse (1994) and Kvale (1996). Eisner (1991) and Woolcot (1992) have continued to explore the underlying philosophical issues. According to Schwandt (1994), the issues can be summarised as follows.

What is an adequate warrant for a subjectively mediated account of inter-subjective meaning...that avoids the charge of solipsism (they are only my accounts) and relativism (all accounts are equally good or bad, worthy or unworthy, true or false, and so on? (Schwandt, 1994, page 117).

These comments confirmed my own emphasis on audit, validation and craftsmanship as a way of resolving those tensions between the extremes of solipsism and relativism, and between a rigid objectivity and an unrealistic subjectivity. Tying these threads above together, a social constructivist model has been defined as follows (Schwandt 1994, page 118):

The constructivist or interpretivist believes that to understand this world of meaning one must interpret it. The inquirer must elucidate the process of meaning construction and clarify what and how meanings are embodied in the language and actions of social actors. To prepare an interpretation is itself to
construct a reading of these meanings; it is to offer the inquirer’s construction of the constructions (sic) of the actors one studies.

This would be a fair summary of the methodological approach to this research on supervision, with validity being defined within this paradigm.

10.12 Summary

This particular research on supervision has attempted to provide an explicit example of theory enhanced research, by firstly detailing the underlying philosophical paradigm, and then by linking those inherent assumptions into the research method and the observational data. To reframe these considerations, this research is a worked example of a social constructivist paradigm.

 Chapters 5-9 presented data from the participants followed by some discussion of each topic and theme. Now that the issues of validity and transferability have considered, the final chapter of discussion can be presented, leading to the implications and recommendations of this thesis.
CHAPTER 11: Discussion and implications

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.

Discussion about supervision was initiated in each of Chapters 6 to 9. This final chapter deepens the discussion to include both practical and theoretical implications. Supervision is uncommon in medicine, and the GPs here were quite articulate about difficulties in starting. Their barriers were both cultural and personal, and how they worked through those has been presented in some detail. Yet once they identified with the process of supervision, they seemed to become enthusiastic about it. How can this be? If this particular method of educational support is so helpful, why is not more common in medicine? The answers to this question lie in the ongoing barriers to supervision in medical culture.

11.1 The barriers to supervision
Firstly, there are several aspects of medical culture that prevent further uptake of supervision. Admission to medical school is still based solely on competitive academic achievement. The Lone Ranger syndrome noted in Chapter 3 leads to many doctors being reluctant to ask for help (Barker, 1998). Students and mature doctors seem reluctant to utilise all aspects of the learning cycle, with reflective learning from experience an uncommon feature of medical training (Freeman, 1997). Mentoring is a poorly understood concept, with few doctors having experience of a mentor-mentee relationship. All these factors contribute to a culture in which talking frankly about the difficulties of one's work is seen as a sign of weakness, rather than of proactive learning.

Secondly, I contend that the underlying philosophical basis of medicine is a significant barrier to supervision. On page 25, Table 3.1 compared the features of objectivist and subjectivist approaches to the nature of knowledge. With respect to ontology, an objectivist view of the world would infer that there is only one reality. This reality is "out there" to be discovered by the diligent scientist. If medicine is
placed in such a paradigm, the practising scientist (the doctor) looks for the one real or true explanation of the events before him/her. In medicine, the “real” truths are individual diseases, which explain the observed phenomena in a patient. This line of reasoning so far is quite clear. Given the system of nomothetic, real, or universal explanations, once the practitioner knows the system of those, he or she is then able to practice medicine, with the task each time of simply finding the explanation and passing that information onto the patient. Knowledge is fixed, and medical culture is oriented toward finding and curing. Knowing enough knowledge becomes the primary task of students or practising doctors, and once that knowledge has been gained, then by definition, further learning is unnecessary. In this paradigm of knowledge and practice, didactic learning and paternalistic approaches to the patient go hand in hand. Supervision is unnecessary, as are other processes of self-reflection, as the person of the doctor is quite independent of the nature of knowledge. Detachment from the patient is mandatory, just like the scientist who is independent of his/her data. Knowledge is fixed and immutable and the practitioner has no requirement to analyse his/her interactions with patients.

In this schema, supervision is considered unnecessary for clinical practice, as it is a method of analysing the doctor-patient relationship, rather than of specific teaching about disease. It is not surprising that most practitioners have no concept of supervision or of other mentoring relationships. In summary, the ontology and epistemology of medicine contribute to one of the major barriers to supervision.

The practical implications here are quite simple. Despite the example from these GPs that supervision is helpful, these barriers to supervision look to be strongly enculturated into medical practice. It seems unlikely that large numbers of current GPs will suddenly start to use supervision or mentoring, even given the efforts of the RNZCGP to promote supervision and other forms of self-care (Barker, 1998). However, it is to be hoped that efforts to legitimise self-reflection at undergraduate level will eventually contribute to an emerging cohort of doctors who are more comfortable with mentoring relationships.

The practitioners here have worked through these cultural barriers. They did so mostly because they discovered that supervision was a method par excellence of
learning how to do psychotherapy in general practice, although the numbers of GPs with such learning needs is small. However, as some IPAs are now limiting their counselling subsidies to only those GPs who receive supervision, it is likely that awareness of supervision will increase. Furthermore, presenting the results of this thesis at conferences would be one way to promulgate supervision as a method of learning about psychotherapy and the doctor-patient relationship. GPs do get some help from their peer groups about their “difficult” patients, but the level of psychological sophistication in general practice about the doctor-patient relationship looks set to remain fairly low.

A practical implication of this thesis concerns the Medical Council’s concept of General Oversight, which requires doctors who are not yet vocationally registered need to have an “overseer”, who monitors their standards of work. In my view, all of the barriers to supervision outlined above will contribute to difficulties in their proposed scheme, as it depends on a satisfactory overseer-doctor relationship (with parallels to the supervisor-doctor relationship). In this case however, the overseer has a summative evaluation role, and so the barriers have the potential to be even greater. It seems likely that emerging doctors will find excuses to avoid Oversight, as one way of circumventing the barriers to an effective supervisor/overseer-doctor relationship.

11.2 The nature of self-knowledge

The GPs in this thesis did not initiate supervision on philosophical grounds. Instead they were driven by their needs and by their patients’ needs. However, as part of continued reflection on their work, they seemed to have developed considerable self-awareness, which is reflected in the number of sections about this in the results. These included for example, reflective practice, experiential learning, career development, roles as a GP, and concepts such as the wounded healer. The outcomes of such wide ranging self-awareness seem to be critical review of one’s task as a helping professional, and the development of an individual philosophy of practice. This has been reflected in their comments on addressing both physical and psychological needs, the doctor-patient relationship, and their relationship with their supervisors, and their role as healer.
Chapter 11: Discussion and implications

For me, the lasting impression of these GPs was the congruency between their theory and their practice. When I commented on this at the Focus group, I was however, met with some resistance. “Not without some struggle”, seemed to be a summary of their replies. I did not go further into that discussion at the time, but it raises the question of why? Why have these GPs in particular chosen this path? Why spend considerable time and energy learning new skills? Self-awareness can also be painful. Something must have been driving these GPs, probably more than simple altruism. My own hypothesis is that one driver of the journeys reported here was intuition; a feeling that somehow things were not quite right. Perhaps an interview of these respondents before they started supervision would have revealed an uncertain restlessness in their orientation to work, or perhaps an undefined feeling of mismatch between their training and their current mode of practice.

Discussion on the nature of knowing in medicine is not well developed, just as there is a lack of emphasis on intuition. It is a well-developed theme in the philosophy of other forms of professional practice however, with Belenky, Clinchy, Golberger and Tarule (1986), Heshusius and Ballard (1996), Polanyi (1958), and Schon (1983) being some examples. Polanyi (1958) was adamant that all forms of science include unstated assumptions from which theory and practice are then derived, with the discussion in Chapter 3 an example of making those assumptions explicit. Schon (1983) emphasised how professionals know more than they can put into words, relying less on formulas learned in training than on an unarticulated improvisation of practice. Belenky et al (1986) studied women’s views of truth, authority, sense of self and moral reasoning. They showed how using intuition, personal meanings and self-understanding led to women “finding their voice”. Heshusius and Ballard’s more recent work (1996) was a collection of personal essays in which practitioners (in education) told of their journeys from an objectivist model of teaching and educational research to more interactive, subjective forms of education and enquiry.

The common thread here seems to be how personal intuition and knowledge, or “finding one’s voice”, impacts on one’s objective knowledge, eventually changing one’s style of practice. I have already noted that intuition is not taught in medicine or considered to be as important as objective findings, but the evidence in this thesis indicates the central place of such intuition in the narrative stories from these
practitioners. Their journeys seem to be from "enculturated objective scientists" (to coin a phrase) to more subjective, self-aware, interactive practitioners who use professional intimacy as part of the therapeutic relationship. It has been the growth of self-knowledge that has been the key to those journeys.

The implication here is that intuition needs to be given more emphasis in medical training. Students and practitioners could profitably spend more time on self-reflection to identify their own self-knowledge. Understanding one's own social and medical culture needs further work in medical school. As already indicated, I believe that current medical culture is dominated by the current paradigmatic crisis, present now for several decades. The links between personal knowledge and such a crisis are outlined in the next section.

11.3 The effect of paradigm crisis in practitioners

In this thesis I have articulated the anomalies of biomedicine in current practice and the epistemological confusion of general practitioners. The concept of anomalies was taken from Kuhn's thesis of paradigms and paradigm revolutions (Kuhn, 1996). His original comments on the effect of practising in a period of paradigmatic uncertainty are pertinent here.

Furthermore, in all these cases (except that of Newton) the awareness of anomaly had lasted so long and penetrated so deep that one can appropriately describe the fields affected by it as in a state of growing crisis. Because it demands large-scale paradigm destruction and major shifts in the problems and techniques of normal science, the emergence of new theories is generally preceded by a period of pronounced professional insecurity. As one might expect, that insecurity is generated by the persistent failure of the puzzles of normal science to come out as they should. Failure of the existing rules is the prelude to a search for new ones. (Kuhn, 1996, page 68, emphasis added).

I was at pains in Chapter 3 on the culture of general practice to point out the growing malaise in general practice, to the extent that the most recent conference (1999) had a forum on "low morale". Various reasons were postulated, but working as a practitioner in the middle of paradigmatic uncertainty was not mentioned. This would
not be surprising, as throughout this thesis I have noted how practitioners of any
discipline are usually unaware of the assumptions of their given paradigm, and would
also be unable to articulate the philosophical issues behind any crisis. However, as
outlined on the previous page, their intuition could give them clues that all was not
well. The well-documented statistics on stress in practitioners and the rates of suicide
and substance abuse (O’Hagan and Richards, 1997) have so far been rationalised in
purely psychological terms (Bennet, 1987; Revel, 1996; Vaillant, 1972). I am
suggesting here that the “fall-out” from working in medicine could also be attributed
to unacknowledged and subconscious paradigmatic uncertainty, in which there is a
mismatch between theory and practice. Practitioners try to force their observed data
into artificial pre-designated categories, which do not necessarily match their clinical
experience.

The categories referred to here are the disease-orientated ones of biomedicine, which
work in certain circumstances, but are insufficient for some of the phenomena of
practice. Social and psychological influences have more impact on illness in the
general practice context, and so it is not surprising that GPs feel the brunt of
philosophical uncertainty before it is felt in other specialities. By contrast, it must be
quite affirming to be working in a paradigm that does not have such a crisis.

Clearly, these comments are deliberately provocative, and do not really convey the
advances in medical thinking of the last few decades. Yet the anomalies are still
present and practitioners continue to have unresolved epistemological difficulties. In
other words, there are ongoing problems in clinical practice arising directly from the
unstated assumptions of the medical paradigm. The practical implications are quite
straightforward. What are required now are lectures in medical school on the
underlying philosophical basis of medicine. These could perhaps start in second or
third year with exposure perhaps, to a medical anthropology approach to illness. This
would broaden students’ conceptual understanding of the place of modern medicine
in a global context, allowing a more objective appraisal of their own discipline. In
fourth and fifth years students have had some clinical exposure to patients. By
starting with their experiences of patients who do not fit the biomedical model
(somatising patients, for example), their expectations of what should occur could be
identified. With some guided discussion, their assumptions about what is knowledge
and about the expected relationship between doctor and patient would emerge. Gradually, a table similar to 3.1 (page 25) could be filled in.

One could expect some resistance, as hitherto such considerations would have been taken for granted (Kuhn, 1996). Comparing the western approach to illness with that of other indigenous cultures could help to give students some objectivity to their discussion. Eventually, students may realise that disease and biomedicine are but useful tools in the service of the patient, but have no intrinsic reality, other than as conceptual frameworks. This would be potentially sacrilegious, but it could serve to trigger further reflection on their received mode of practice, where their techniques of practice need to be linked to their philosophical assumptions (Polanyi, 1958). I have made application already to give these lectures to the fifth year class as part of their professional development programme. It will be interesting to see if such lectures give students more freedom in their approach to the patient. Rather than blaming the patient who presented with undiagnosable difficulties (Groves, 1981; Ries et al, 1981), or feeling bad about their own inadequacies, doctors instead could realise that it is the model that is the problem, rather than those working within it. As noted before, this discussion is not to deny the place of good clinical medicine; rather, these ideas are directed at the anomalies of practice that prove so distressing and confusing to doctors and patients alike. Discussing these issues with students would be one practical outcome from this thesis.

How have the practitioners in this research coped with these paradigmatic uncertainties? I believe the answer is in the role of the supervisor as facilitator and in supervisor’s task of validation, the effect of which will be outlined in the next section.

11.4 Validation

Much of this discussion so far has been about personal knowledge and self-awareness. In Chapter 5 (Dissonance and exploration), there were also sections on validation and on the relief of having a safe forum in which to discuss one’s work. In Chapter 8, the first two sections were on challenge with safety and on self-awareness. All of these topics have a common thread of personal validation of the doctor from the supervisor about his or her experience of their work. Far more than being just an educator, the supervisor’s role of facilitator seems to have been crucial in the
fostering of professional awareness of the supervisee. This validation seems to authenticate and verify the doctor's professional ideas. In turn, this has led to fairly rapid professional growth by these doctors, with clearly articulated ideas on their philosophy of practice and the place of supervision. Validation then, has been a crucial aspect to these stories and furthermore, their interviews revealed how they earned that validation, rather than being given it as a matter of course.

What does validation do? How can it be so powerful on the supervisee, or "validee"? How does having one's experiences heard and reflected back, allow further growth? While it is probably beyond the scope of this thesis to answer those questions, it is worth noting the historical influence of Rogers (1951), who emphasised the experience of the client as the basis for therapy. Perhaps acknowledging, exploring and validating the experience of the supervisee is also the basis of good supervision. "Knowing someone else knows" seems to be an important component of the power of validation, and further discussion would necessitate a deeper reading of philosophical texts. At present, the evidence from this thesis suggests that validation of these GPs by a trusted and respected supervisor allowed professional and personal growth in a time of considerable epistemological uncertainty about the nature of practice. The place of supervision then, has been to enable these supervisees to survive and flourish when the rest of general practice has been complaining of low morale and considerable work-related stress.

The Dunedin School of Medicine has started a process of validation in 1999 in the mentoring scheme of the professional development programme. Early reports so far from the mentors indicate that their role as facilitator was critical in their debriefing of medical students, some of whom experienced considerable transitional stress as they encountered patients clinically for the first time. The implication from this thesis is that such validation is important at many points in a medical career. Despite some opposition to the mentoring scheme, it would be advantageous for students to have a positive experience of mentoring and validation early on in their clinical work.

11.5 The resolution of paradigmatic crisis
The final implication of this thesis is that supervision appears to be a method of resolving the paradigmatic crisis outlined at length in Chapter 3. Kuhn detailed how
individuals react to a crisis in their field of work. "The decision to reject one paradigm is always simultaneously the decision to accept another, and the judgement leading to that decision involves the comparison of both paradigms with nature and with each other" (page 77). The individual practitioners here seemed to have identified the problems with biomedicine, but rather than rejecting it, have incorporated its strengths into a wider framework. For a profession, though, how does one dominant paradigm become succeeded by another? Figure 3.1 on page 39 outlined the process of scientific revolutions, and once again Kuhn's original text is relevant here.

*What is the process by which a new candidate for paradigm replaces its predecessor?* Any new interpretation of nature, whether a discovery or a theory, emerges first in the mind of one or a few individuals. It is they who first learn to see science and the world differently, and their ability to make the transition is facilitated by two circumstances that are not common to most other members of their profession. Invariably their attention has been intensely concentrated upon the crisis-provoking problems: usually, in addition, they are men so young or so new to the crisis-ridden field that practice has committed them less deeply than most of their contemporaries to the world view and rules determined by the old paradigm. How are they able; what must they do, to convert the entire profession or the relevant professional subgroup to their way of seeing science and the world? (Kuhn, 1966, page 144, emphasis added).

For these GPs, one of the crisis-provoking problems was the mind-body dualism that has been the central anomaly in medicine for several centuries. This stemmed from Descartes and Newton, and while the artificial split between mind and body has been conceptually useful to acquire knowledge, its application to clinical medicine means that bodies and minds are considered as separate entities with no connection between the two. Patients with undiagnosed abdominal pain, recurrent cystitis without proven infection, or tension headaches (to name just a few examples of somatisation) are often over-investigated, while their symptoms are poorly explained.
Chapter 11: Discussion and implications

The GPs in this research seemed to have worked their way through these difficulties. They were comfortable with the somatising patient, sometimes attempting to increase the patient’s psychological awareness as part of treatment. Further, when asked about their philosophy of practice, none of them indicated that their primary purpose was a search for disease or its cure. By contrast, all them listed instead their relationship with their patients or finding the “real thing”. In other words, their raison d’être became the relief of suffering through the doctor-patient relationship, just as Cassell (1976) had predicted over three decades ago. In these ways, these GPs are demonstrating a resolution to the contradictions inherent in biomedicine, by focusing not solely on disease, but on the patient as a person with suffering.

The implication here is that the purpose of practicing medicine needs to be opened up for discussion. Is the primary task of the clinician to diagnose disease, or is it to relieve suffering? Is the concept of disease an end in itself, or is it just a useful tool? I initiated lectures on suffering by Cassell to conferences and to medical schools in his visit to New Zealand in 1998, and such discussion has continued in the Masters programme for general practitioners. In this way, there is already an increasing debate on the place of suffering in the modern approach to illness.

Similarly, clinicians need further help in their approach to the somatising patient. Broom from Christchurch has already started to speak to medical schools and to general practitioners about his resolution of the mind-body dualism. In this way, there is further discussion about the epistemology of medicine, and the difficulties of practice become more explicit. What I would like to see is more debates on the underlying philosophical assumptions in medicine. Why have guidelines based on controlled trials, for example, been implemented poorly in clinically practice? The answers lie in philosophical considerations. It seems unlikely that terms such as social constructivism will be readily used, but that is the level at which discussion is required.

11.6 Supervision, the patient, and the doctor

This has been a long discussion so far without much mention of the patient. Yet in the background the patient has been the unacknowledged reason for this thesis. These doctors are after all, helping professionals and their task is in the service of others. It
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may be relevant to ask: “How are they doing? Are they doing a good job as a helping professional, and does supervision facilitate their task?”

There are several answers to these questions, not all of which can be answered by way of the research here. Firstly, it seems likely that because the doctor has been validated and supported by the supervisor, he/she is able to validate and support the patient. Similarly, by close attention to the “state” of the supervisee, the supervisor models how the doctor can pay close attention to the state of the patient, including affect, personal development and so on. From the stories presented in this thesis, one conclusion is that these GPs do in fact, attend very closely to the needs of their patients, and are able to focus on both physical and psychological factors as required. The end result of the GP having supervision is an enhanced appreciation of patients’ experience of illness, and increased professional respect for the patient. It seems likely that that will increase patient satisfaction, and in the long term, may improve other outcomes of illness.

Secondly, in answer to “How are they doing?” the answer seems to be “Pretty well”. Professionally and personally, these GPs seem to be coping and even thriving. They seem to enjoy the challenge of general practice at present and have a high morale, rather than a low one. It would be rather incongruous if the administering doctor was less healthy than his or her patients were; supervision seems to contribute to a healthier functioning of the health professional. In summary, supervision seems to be an effective and powerful method of professional maintenance.

However, while the RNZCGP may find these findings interesting, I do not recommend that supervision be made compulsory. As I have pointed out at length, the barriers to supervision or other forms of mentoring are endemic in medical culture and any compulsion would only increase the resistance. The implication is that supervision will gain acceptance by the example of those enjoying it as a method of support and development. As other GPs observe that the supervised practice is a healthy and well-functioning form of health care delivery, they may become curious and may want to emulate such practitioners. Word of mouth may be the best form of advertising.
11.7 Summary and conclusions

This has been a long and complex thesis. It is the culmination of five years of part-time study for the Masters degree, but it also represents some twenty years of work as a practising doctor, most of which has been in general practice. In my own experience as a GP, I have been struggling with the issues here in practical terms for many years. Furthermore, I have been teaching the Nature (or philosophy) paper of the Masters degree in General Practice for the past three years, affording me a unique opportunity to reflect on the underlying themes and issues in general practice. Doing this research has enabled a clarification and crystallisation of my ideas that would not have been possible otherwise. The conclusions from this integration of practice, theory and research are as follows.

Modern medicine has been derived from the scientific approach to the discovery of knowledge, and the advances in understanding of the body have been enormous. Medical interventions have transformed the approach to illness. However, the current model of medicine has its limitations, and I have used the work of Thomas Kuhn to identify just how those limitations have arisen, and how it is likely they will be resolved. While the epistemological stance of objectivity has been scientists' greatest strength in the last few centuries, it has also led to paternalistic approaches to medical care and didactic forms of medical education. In my view, the injudicious application of scientific objectivity to the care of the individual patient has been the major stumbling block of biomedicine. By contrast, the GPs in this thesis employ a relationship-based model of medical care that seems effective for their patients. My interpretation is that they practice medicine more in a social constructivist model, where knowledge, truth and outcomes are constructed from the interaction between doctor and patient.

Paradoxically, medicine is not a “learning culture”. This is because of the emphasis on content (or knowledge) to the exclusion of consideration of process. Once again, it has been the study of the GPs using supervision that has highlighted the relative lack of learning about process and content in the medical community. Identifying Kolbs’ stages in the learning cycle shows how medical practice is generally deficient in the stages of reflection or abstract conceptualisation, with most doctors going from experience, to experience, to experience, without having the opportunity to learn and
grow from those experiences (Kolb, 1984). This is not to be too critical; most medical practice in New Zealand is provided at a very high standard. It is likely that practitioners do learn from their work, but that their learning methods could be further facilitated. What blocks a more widespread use of reflective learning is the unfortunate legacy of the destructive learning culture of medical schools, from which some graduates have emerged in an almost post-traumatic state, being quite self-critical, and seeing most forms of feedback as negative criticism. How the GPs here have worked through these barriers for themselves has been a major part of this thesis.

The research method in this thesis has been articulated at length, as I felt that the method of research and the underlying philosophical model needed to be congruent. Further, it is only through an explicit interrogation of the method that valid conclusions can be drawn, and it is only through considerations of validity that any inferences or implications can be made. The research performed here is consistent with a social constructivist model of enquiry, in which the discovery of "truth" is dependent on complex social interactions.

Finally, the basis for medical practice outlined by these respondents is through the doctor-patient relationship, with their practice of medicine being located (once again) in a social constructivist model. One implication in retrospect is that clinical practice was never located in biomedicine and that medicine as a science has been one of the great myths of the twentieth century. It will be through the continued example of GPs such as these that we can come to a more accurate appreciation of medicine as interplay between science and the complex interaction of doctor and patient.
REFERENCES


Baron, R.J. (1985). An introduction to medical phenomenology: I can’t hear you while I’m listening. Annals of Internal Medicine, 103(4), 606-611.


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APPENDIX 1: Initial letter to prospective participants

Name
Address
May, 1998

"Why are General practitioners using professional supervision as a method of professional maintenance."

Dear (Name),

I would like to invite you to take part in the above study, which is the final part of my Masters degree in General Practice. My aim is to find out why general practitioners are using supervision, and to collect together some of the common themes and issues. I would like to know what led you to start supervision, what benefits you get from it, how your use has changed or developed over time, how it has been useful or otherwise, why you continue to use this particular method of professional maintenance, how the process of supervision has influenced your working life in general, and of course, anything else you wish to mention.

I have asked you to participate on the basis that I understand you use the method. I wish to interview up to 12 participants over the next few months. For you, this will involve a careful reading of the consent form and either discussing it further by phone, or signing and sending it back to me. I will then contact you and discuss any further questions, and arrange a time for an interview. I expect this will take one to two hours and the interview will be audio-taped for later transcription. This will be done by Ms S Minchin, transcription secretary in the Department of General Practice, with appropriate regard for confidentiality. The only persons with access to the raw data are myself, my secretary and my thesis supervisor. You may withdraw at any time without giving a reason, and can withdraw your data at any stage. Your participation is entirely voluntary.

After I have collated the data and themes I will write the thesis. This is based on the principles of qualitative research and 'grounded theory'; that themes and issues arise from the experience and text of the participants.

No material which could identify you, will be used in any reports on this study. All data will be stored safely to maintain confidentiality, and your own audio-tape can be returned to you at the end of the study, if required. You may receive a complimentary copy of the final draft of the thesis if you wish. This study has received ethical approval from the Southern Regional Health Authority Ethics Committee, August 1997, which covers both Otago and Canterbury. If you have any concerns about this study you may contact; Associate Professor Jim Reid, Thesis Co-ordinator, Department of General Practice, University of Otago, phone - (03)4797430

I look forward to hearing from you in due course.
Yours sincerely,

Dr Hamish Wilson,
Master of General Practice student,
Dunedin. Masters Supervisor: Dr Anne Bray, Donald Beasely Institute, Dunedin
CONSENT FORM
"Professional supervision for GPs."

I have read and I understand the letter, dated May 11, 1999 for volunteers taking part in the study designed to investigate general practice supervision. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study. I have had time to consider whether to take part. I know who to contact if I have any questions about the study.

I consent to my interview being audio-taped
YES/NO

I wish to receive my tape back at the end of the study
YES/NO

I wish to receive a copy of the results
YES/NO

I ..............................................
(full name)
hereby consent to take part in this study.

Signature
Date

Contact Numbers;

Phone; Dr Hamish Wilson (03) 4797430, Home; (03) 4679941
Fax; (03) 4797431, Home; (03) 4679942

Dr Anne Bray (supervisor), (03) 4792162
APPENDIX 2: Second letter to participants about the focus group

1 July, 1999

Dear (Name),

**Re: supervision research**

I am writing once again! I have been working quite hard in the last few months to analyze all the interviews, and they are all full of rich and valuable data. The enclosed thematic summary sheets are my attempt to summarise the issues and ideas you all talked about in your interviews. A major part of the validity or internal rigour of this research is to see if this interim summary sheet rings true for you. What I would like to do is to have a **teleconference 'focus group'**, where we discuss these general themes in more detail. There will be no cost to you. Please ring 083033 to get onto the teleconference network and then the PIN number is 319912. We will use first names only in the teleconference. If you agree to join the focus group, could you please send back the signed consent form in the SAE, suggesting an alternative time if **8pm Tuesday, 20 July** is not possible for you.

The proposed frames of reference for the teleconference discussion are;

1. Is 'supervision as part of a reflective practice' a fair summary of your use of supervision?
2. What are the specific features of the supervisor-doctor relationship that make it so powerful?
3. What are the features of the current culture of medical training and practice that make the concept of supervision so foreign to most doctors?
4. Has supervision resolved the 'dissonance' between your beliefs about how your practice should be, and the reality of practice before you started supervision?
5. What are the features of the doctor-patient relationship that facilitate healing in the patient?
6. What are the barriers for you to become mentors for other GPs?
7. Should supervisors be psychotherapists rather than doctors?
8. Why is it difficult for the doctor-as-patient to experience healing (in the doctor-patient relationship?)

I expect the teleconference to take about 60 minutes. I very much appreciate your ongoing support for this project.

With kind regards

Dr Hamish Wilson
Consent form

I agree to join the focus group on supervision themes at Tuesday 20 July at 8 pm, and realise there will be no cost for me. I have put this date into my diary!!

SIGNED:

NAME Date
APPENDIX 3: Summary of focus group discussion. July, 1999

Participants in the focus group:

- Have dissonance in practice, so reflect on it, feel validated by supervisor, are validated about being different to peers, are able to continue in their own way.
- Want challenge, in a place of safety, to resolve dissonance.
- Dissonance may be resolved, without being integrated back into mainstream medical community.
- Many purposes of supervision; have protected time to reflect on work and be challenged, while being affirmed as internally congruent; this lightens the load.
- Need to make a prior decision to do this, which emphasises the importance of the one to one relationship.
- Safety allows challenge, which leads toward enlightenment.
- Why start; previous medical student experiences needed a protective shell, so need to find new models.
- There’s an ongoing need for resolution of dissonance, sometimes involving practice management, as much as “easy-peasy” patient stuff.
- Part of healing is recognition of the self in the other, and being able to bracket that, as well as a commitment to the patient, even if there’s no diagnosis. Can we notice when we’re not there for that patient?
- As doctors, it is hard to be a patient - we know too much, we don’t like letting go of control, we deny what it is, yet a physical complaint is a better justification for being ill. Doctors have certain injunctions on them from being in the persona of the doctor.
- As a doctor in the patient-role, one can’t be naïve about the doctor-patient process, and wish the doctor would treat them as a patient, rather than a colleague. Perhaps doctors don’t maintain the doctor-role well, with a colleague-patient. This could be similar to interacting with patients from other cultures, where the doctor needs to negotiate between different belief systems. With a doctor as patient, their belief system implies a unique solution to their participation.
- Barriers to being a mentor or supervisor to others include feeling inadequate, working in the same proximity, needing a supervisor yourself, needing to be psychotherapeutically aware, (compared to two doctors “co-mentoring”) and being aware that one is different to the mainstream.
- Mentoring and supervision need to be defined; supervision is more about process. GP supervisors could be seduced into content, whereas one expects process from a psychotherapist.
- Reflecting about supervision has been integrating, and validating.
- Barriers to GPs having supervision include their perception of it; frightening, of no value, horrified, waste of time, while others are simply dis-interested. There may be resistance to the learning about self, or see supervision implying you’ve got a problem, rather than thinking creatively.
APPENDIX 4: Principle texts used in this thesis

On supervision


On qualitative research


On patient-centred method

On somatisation

On biopsychosocial model

On social constructivism


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On scientific paradigms


On the doctor-patient relationship/suffering


On stress in general practice

APPENDIX 5: Glossary of terms

**Empiricism** doctrine that all knowledge is derived from sense-experience; theory that concepts or statements have meaning only in relation to sense experience

**Epistemology** the branch of philosophy that deals with the varieties, grounds and validity of knowledge; the relationship between the knower and what is known

**Essentialism** that essence is prior to existence i.e. a belief that things (including human beings) have a set of characteristics which make them what they are, and that the task of science and philosophy is their discovery and expression

**Existentialism** a person (unlike a thing) has no predetermined essence, but forms his/her essence by acts of pure will and by the very act of existing as a being

**Idiographic** concerned with the individual; descriptive of single and unique facts and processes

**Logic** the branch of philosophy that deals with forms of reasoning and thinking, especially inference and scientific method; a chain of reasoning.

**Materialism** doctrine that consciousness and will are wholly due to the operation of material agencies; nothing exists except matter, and its movements and its modifications

**Nominalism** doctrine that abstract concepts are mere names without any corresponding reality

**Nomothetic** of or pertaining to the study of discovery of general laws; from nomos (Greek) - the law of life.

**Objectivism** the belief that certain things (especially moral truths) exist apart from human knowledge of perception of them; the tendency to lay stress on what is external to or independent of the mind

**Ontology** the science or study of being; that part of metaphysics that relates to the nature of being or essence

**Paradigms** a mode of viewing the world, which underlies the theories and methodology of science in a particular period of history

**Phenomenology** theory that the pure and transcendental nature and meaning or phenomena and hence their real significance can only be apprehended subjectively.
Positivism a philosophical system elaborated by Auguste Compte recognising only observable phenomena and rejecting metaphysics and theism; every intelligible proposition can be scientifically verified or falsified

Realism doctrine that matter as the object of perception has real existence independent of a perceiving agent

Soteriology the doctrine of salvation

Subjectivism doctrine that knowledge, perception, morality etc is merely subjective and relative and that there is no objective truth; a theory or method based exclusively on subjective facts

Voluntarism a theory that regards will as the fundamental principle or dominant factor in the individual.