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Workplace and Specialty Specific Culture and Practice in Clinical Supervision A Multiple Case Study

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Background

- Starting point for this study was a realist theory of clinical supervision - developed through a realist review

Process	Mechanisms
Supervised Participation in Practice	**Entrustment & Support Seeking**
Mutual Observation of Practice	**Monitoring & Modelling**
Dialogue About Practice	**Meaning Making & Feedback**

- Clinical environments unique in their culture, practice, and work activities; to gain a better understanding of how these contextual factors shape clinical supervision - investigate multiple specialties and in different workplaces

Method

Four medical departments were purposefully chosen to investigate clinical supervision in different contexts regarding organisation and specialty

Case#	Specialty	Workplace	Participants
1	Geriatric Medicine	Second Largest University Teaching Hospital in Ireland	Trainees n=9 Consultants n=4
2	Vascular and Gastrointestinal Surgery	Acute General Hospital	Trainees n=11 Consultants n=1
3	General Paediatrics	Acute National Paediatric Hospital	Trainees n=9 Consultants n=5
4	Infectious Diseases	Largest University Teaching Hospital in Ireland	Trainees N=9 Consultants n=2

Method

- Interviewed **50 consultant and trainee participants** representing a range of disciplines and training levels
- Interviews were typically 30-60minutes in duration
- What a typical workday is like
- What activities they engage in
- How they prioritise work
- How they interact with their seniors

Analysis

- A two-step qualitative data analysis procedure
- **Pattern-matching** and **cross-case analysis**, within the case and across cases.
- Testing consists of matching an **'observed pattern'** with an **'expected pattern'**
- Realist theory of supervisor-trainee interactions as an analytical lens
- Cross-case analysis to examine similarities and differences within each of the domains.

Results

- All the processes proposed by the realist theory on supervisor-trainee interactions were experienced across all four cases
- Participants described how entrustment develops, how trainees discuss cases with senior doctors, and the feedback that trainees receive on their performance
- Cross-case analysis revealed case-specific characteristics which shape the way clinical supervision function within different specialties and organisations

Entrustment

- Across all cases, trainees had limited autonomy

Several reasons relating to the local culture and practice which led to this:

- An over-reliance on junior trainees (e.g., interns and SHOs) to perform routine ward-based tasks = limited affordance of progressive responsibility for more complex activities

- Rotations and working hour regulations = trainees didn't have the same relationship with patients like consultants
    - Ownership of patients
    - Difficult to develop trust in trainees

Entrustment & Support Seeking

- In **Case 1(Geriatrics) and Case 3(Paediatrics)**, trainees of all levels were very protected, closely supervised and were afforded very little independence.

"You would work very closely with your consultant and your consultant led team to the point where I suppose of the nature of the jobs that they are, they have to be consultant led so you don't get a lot of scope as a registrar to kind of I suppose take on a certain amount of responsibility yourself because every time something happens you have to ask them is it okay if I do this." ***T3C3***

- The decision to seek support from a senior is a complex process

- **Case 3(Paediatrics)**, in particular, support seeking most acceptable and actively encouraged by consultants = occurred more frequently

Local Culture & Practice

- **Case 3(Paediatrics) and Case 4(Infectious Diseases)**, trainees never attend handovers, firstly because of working time regulation, but it is also culturally related to those sites; junior trainees weren't expected to be there

- **Case 1(Geriatrics)** – traditions within the department directed in what activities trainees participate

"Again maybe I am too much of a traditionalist but we have worked this system here… the consultants receive the case notes after discharge and do the summary fairly quickly and it gets out to the GP then quite promptly so they get a very accurate crisp account of what happened and what the follow up plan is... Our G.P. colleagues over the years, over the decades have been very happy with that service. I think we are still one of the few services where the summary is done by the consultant... I suppose we are high done by tradition maybe." ***C4C1***

Conclusions

Findings not easily transferable to other settings

Important that people involved in postgraduate medical training identify contextual factors relating to their department or organisation which may have an impact on the supervision of trainees

Local culture and practice shape supervisory processes such as entrustment, support seeking and how supervisors and trainees observe and communicate with each other, and therefore can have an impact on the professional development of doctors-in-training

Thank you for your attention!

Any Questions or Comments?

Level of Training

- **Case 1(Geriatrics) and Case 3(Paediatrics)**, the level of trainee did not necessarily determine what clinical tasks they were entrusted with and there was little variation especially between intern and SHO level.

- Conversely, in **Case 2(Surgery)**, job descriptions of different levels of trainees were clearly demarcated.

Efficiency

- In **Case 3(Paediatrics) -** the team often work through cases separately = not together to observe each other

- Trainees miss out on opportunities to do even simple procedures because more experienced doctors can do them much faster than their junior counterparts

- In **Case 2(Surgical)**, junior trainees miss out on observational learning opportunities because they spend very little time in theatre because they must take care of ward-based jobs.

- *"The other thing is, there is lots of skills which medicine used to do and have that are kind of going away and so there is lots of things like chest drains, abdominal drains and I would say soon enough, lumber puncture and things like that which were always done by medics on the wards, you know."* ***T5C4***
- *"For two reasons, one is consequences as you have said so the more senior people are doing it, they are going to do the lumber punctures, they are going to do the biopsy's and then the second is obviously the role of interventional procedures in doing some of the biopsy's or procedures that we would have done as trainees... Now you never do a liver biopsy like."* ***C1C4***