COMMENTARY

Dietitians and supervision: should we be doing more?

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Abstract

As the role of the dietitian has expanded over recent years, many are becoming increasingly involved in the care and management of vulnerable individuals, both alone and as part of multidisciplinary teams. This raises an important question – how are we as a profession managing our changing role in the health care setting? The advent of Clinical Governance means there is a need for dietitians to join the debate on the issue of supervision, which has been raging in the nursing and other health professions over recent years. This article attempts to define the terms supervision and clinical supervision both globally and in the context of dietetics, to describe models of clinical supervision being used in other professional groups and to put forward a framework for addressing whether there is a need for clinical supervision in all areas of dietetic practice.

Introduction

'In the caring professions where personal interactional skills are at the forefront, only by supervision can some attempt be made to measure both the quality of the standards of care and the demands on the client and worker' (Byrne, 1994).

The last 10 years has seen an expansion in the number of dietetic posts within the mental health setting. In such a capacity, dietitians are becoming increasingly involved in the care and management of vulnerable individuals, both alone and as part of multidisciplinary teams. Working with individuals experiencing psychological or emotional pain, who cannot always disentangle such issues from the dietetic encounter, can be extremely stressful. This is perhaps best illustrated by the sufferers of eating disorders and it is not unusual for dietitians working in this field to be confronted with issues that they may not feel psychologically able to manage. These issues are not confined to the mental health field but may be encountered by dietitians practising in a variety of settings, for example, paediatrics, working with the terminally ill and palliative care. This raises an important question – how are we as a profession managing our changing role in these fields? In particular, it identifies a need to join the debate on the issue of clinical supervision, which has been raging in the nursing and other health professions over recent years. Before this can happen, we need to consider the meaning of supervision in the current NHS climate and how it is generally applied. The aims of this article are therefore to define the terms supervision and clinical supervision both globally and in the context of dietetics, to describe models of clinical supervision being used in other professional groups and to put forward a framework for addressing whether there is a need for clinical supervision in all areas of dietetic practice.

What is supervision?

The *Oxford English Dictionary* definition of supervision is 'to oversee the execution of a task or the actions or work of a person'. This implies that the

process of supervision is active on the part of the supervisor and passive on the part of the supervisee (something done to them), and it fits well with the experience of most dietitians. For many of us, supervision means being observed during training and in the early stages of our careers, a stage that we all need to pass through, on our way to becoming competent professionals. For some, it may also be seen as a threat – a challenge to individual competence, but a necessary evil. Yet supervision should not be synonymous with observation and, indeed, is regarded very differently in other professions, particularly those working in the mental health field. Here supervision (or clinical supervision as it is more commonly known in this setting) is a fundamental part of the role of a carer. Much of the literature on clinical supervision consequently relates to social work, nursing and the psychological and occupational therapies. In these professional groups, clinical supervision is more likely to be viewed as 'the cornerstone of clinical practice' (Hill, 1989) and in some, such as midwifery and social work, clinical supervision is a statutory requirement (Devine, 1995). Wright (1989) suggests that clinical supervision be viewed as the opportunity to 'think about what has happened, why it happened, how it was handled, could it have been better or different?' This is best encapsulated in the term 'reflective practice'. Perhaps the most appropriate definition for the dietetic profession is one that is put forward in the nursing document *A Vision for the Future* (Department of Health, 1993). This states that 'clinical supervision is a term used to describe a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety or care in complex clinical situations. It is central to the process of learning and to the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills'. Inherent in this definition should be the need for supervision to be undertaken in a safe environment, providing the opportunity to explore and reflect in a supportive and confidential setting.

Clinical supervision should not be confused with mentoring, which is another issue of importance to the profession, outlined in a recent guidance paper (BDA, 1998). According to the definition in this document, the word 'mentor' means trusted adviser, friend and counsellor. The subtle distinction between supervision and mentoring often lies in the power divide, whereby the mentor is more likely to be a more experienced practitioner than the person receiving the mentoring. This is perhaps best illustrated by the relationship between a qualified dietetic mentor and a dietetic student on placement, or by that of a newly qualified dietitian and a more experienced one. Clinical supervision, on the other hand, has been described as 'an exchange between practising professionals to enable the development of professional skills' (Butterworth & Faugier, 1992). While mentoring has been identified as important by the profession, it has not yet become routine practice. Clinical supervision has even further to go before being accepted within our profession in the way it is within others. So why is it an important issue to address?

Why is clinical supervision important?

At the Post-registration Course in Eating Disorders held in May 1999, the importance of clinical supervision was discussed among delegates, who had variable experiences of receiving clinical supervision for their work with clients. The consensus view was that dietitians working in mental health and eating disorders required some form of supervision, to help deal with some of the difficult behaviours and relationships encountered. Eating disorders are becoming increasingly prevalent and represent an area in which dietetic intervention is now widely accepted. If we also consider that the prevalence of binge-eating disorder in obese patients attending for weight-reducing advice is estimated to be 20–30% (Marcus, 1995), it is likely that most dietitians in clinical practice will at some point come across a patient exhibiting varying degrees of psychological distress. The consequence of a highly charged encounter, once the patient has left the room, is often to leave the dietitians themselves feeling emotionally drained and stressed. We have all had the experience of finding our

thoughts returning to such situations even after we have left work behind at the end of the day. If such situations are routinely encountered, as may be the case in the mental health field, some strategy for dealing with them needs to be devised. If this does not happen, stress and burnout are the inevitable consequences (Treasure *et al.*, 1995). Little is known specifically about the levels of stress experienced by dietitians – we must turn to the nursing literature for comparison. Stress has been linked with reduced levels of job satisfaction, poor work, staff burnout and illness (Cooper & Hingley, 1988). These in turn have resource implications. For example, the organizational costs of staff absence in a London teaching hospital were estimated to exceed £1 million, when account was taken of the costs of covering for absent staff (Seccombe & Buchan, 1993).

So far, we have addressed the need for supervision using an argument based on providing support in the face of dealing with distressing situations. Yet, the need for the profession to begin a debate about clinical supervision is even more pressing, with the introduction of Clinical Governance. These changes are destined to have a significant impact on dietetic practice in the future. The concept of Clinical Governance is best described as 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish' (Department of Health, 1998). In other words, quality of care is to be accountable. Dietitians have already come a long way in addressing this, with the development of the National Professional Standards for Dietitians Practising in Healthcare (1997). Two of these standards are worth reproducing here. Standard two states that 'dietitians engage in self-development to improve knowledge and skills in order to remain competent to practice' while standard six states that 'dietitians are responsible for an explicit quality of service'. What the white paper is striving for is a more formal process for implementing and monitoring these important working practices. The differing types of supervision and their application to the dietetic profession will now be discussed.

Models of supervision

For a description of the types of supervision that best fit within a dietetic framework, we have again searched the nursing literature. In the developmental model proposed by Hawkins & Shohet (1989) it is suggested that clinical supervision has three distinct functions:

1 the educational function is about developing skills, understanding and abilities of the individual;
2 the supportive function deals with the stresses and difficulties that are experienced by preventing the individual from becoming overwhelmed by clients' problems and allowing them to deal with any emotions that this relationship may engender;
3 the managerial function provides quality control and feedback about clinical practice.

They also suggest a number of approaches to the process of supervision, three of which are outlined in more detail below, with emphasis on how they might be applied in dietetics. These approaches may encompass one or more of the above functions, depending on the nature of the supervision on offer.

Self-supervision

This relies on the individual's ability to reflect upon their work. It requires both prior knowledge of the supervisory process and a depth of knowledge of the work being carried out. According to Bond & Holland (1998, p.14) 'the capacity for, and skills in, reflective practice are key components of clinical supervision'. The BDA has embraced the ethos of the 'reflective practitioner' in its policy for Continuing Professional Development (CPD). In the majority of health professions, learning does not stop at the end of the course of training but is a career-long process. At the moment this process is not a statutory part of competence to practice, although in time may become so. Indeed, the 1996 review of the 1960 Professions Supplementary to Medicine (PSM) Act recommended that there should be some evidence that practitioners continue to keep themselves up to date with current practice to maintain state registration. Examples of how this can be achieved include the Diploma in Advanced Dietetic Practice, which formally recognizes CPD

activities, and BDA-validated courses, such as the postregistration course in Eating Disorders, which offer the opportunity to enhance skills in specialist areas of dietetic practice. It is therefore the responsibility of all dietitians to reflect on their practice and to operate some form of self-supervision.

One-to-one supervision

This is perhaps the most widely found model of supervision and the method that most people instinctively feel comfortable with. It requires a depth of knowledge of clinical practice plus skills in interpersonal relationships. In other mental health professions, the supervisor in this situation is usually from the same professional group, for example nurse supervisee to nurse supervisor. However, because of the smaller number of dietitians working in mental health, their supervision is likely to come from someone outside their professional group, who has an understanding of working practices in this setting, for example dietitian supervisee to nurse supervisor. It is important therefore that supervisor and supervisee have a mutual understanding of professional as well as practice issues.

Team supervision

The increasing number of dietitians working in multidisciplinary team settings may lend itself to the development of the team supervision model, and at first glance, this does seem to offer an advantage in terms of time, if the whole team is seen together. It also facilitates patient care, since the whole team can address issues arising from dealing with a particular client. However, there is a need for the supervisor to have experience of group dynamics and to be aware of the relationships between different team members. This is particularly important in multidisciplinary settings, where problems are often experienced around professional rivalry and the blurring of roles. Supervision can help to address these issues by developing teamworking and providing insight into those areas where roles might be blurred.

Other types of supervision include consultative supervision (Gallesich, 1985), whereby a supervisor can seek help and advice on case work; organizational supervision, which addresses issues raised at the level of the organization as the name implies, and network supervision, which is similar to the team supervision concept, in that it is concerned with the whole network of workers organizationally concerned with particular patients or clients (Hawkins & Shohet, 1989).

The type of clinical supervision that might be offered in the mental health field is likely to be of a more supportive nature, exploring the dynamics of an interaction and the supervisee's response to difficult encounters. Clinical supervision for staff can therefore be viewed as a fundamental component of the management of eating disorders and other mental health problems. But what about dietitians working in more generic areas? Clinical supervision may also begin to take on greater importance in other areas of practice as a means of ensuring quality of care. This type of supervision is therefore likely to be more educational or process-driven. Both these methods have their strengths and weaknesses, and depend largely on the situations encountered. For example, concerns have been raised that the supportive role of clinical supervision is a means of 'therapy' (Yegdich, 1999), particularly if the supervisor resorts to interpreting the supervisee's motives (Gediman & Wolkenfeld, 1980). This is a potential problem in settings where more psychotherapeutic work is undertaken, such as the mental health setting. The language and methods used in mental health differ greatly from those encountered in the general health care fields and dietitians working in mental health often need to adapt to the cultural changes encountered. This is particularly noticeable in the move to more psychological approaches to working described by dietitians working in the field of eating disorders (American Dietetic Association, 1994). Dietitians are not particularly thoroughly trained in the types of interactions that take place in therapy – there simply isn't the time within the current undergraduate programmes of study. We also need to ask whether we should be, since there is a danger in dabbling in areas for which we are ill prepared. Instead, should we just be clear about where our boundaries lie? This in itself is another issue

requiring discussion as dietitians move into different areas of working.

A concern expressed about the educational role of supervision is the feeling that it is really only another means of regulation by management. This problem is compounded if the supervisor is also the manager of the supervisee (Goorapah, 1997). It has been suggested that managers are not involved in clinical supervision, especially if they have no clinical function (Kargar, 1993; Darley, 1995). However, in a profession as small as dietetics, this is unlikely to be an option available to many. Instead, this type of situation can be addressed by the establishment of clear boundaries in the supervision relationship, or the establishing of a supervision contract (Bodley, 1992). If issues do arise in which poor performance is identified, strategies must be in place to address this within the supervision framework. Occupational Therapy, for example, encourages the signing of confidentiality contracts between the supervisor and supervisee to manage problems arising as a consequence of the supervision session (College of Occupational Therapy, 1997). In some cases, there may be distinct advantages to being supervised by someone who no longer has a clinical role, including detachment, objectivity and a more holistic view of the situation.

Supervision in practice

There are some who believe that clinical supervision is a requirement of all qualified practitioners in all clinical areas, to maintain proficiency to practice, ensure their accountability and to aid personal and professional development (Bond & Holland, 1998). But is supervision within dietetics necessary or is it just another administrative burden to cope with, alongside Clinical Governance, National Professional Standards for Dietitians Practising in Healthcare, CPD and countless other initiatives? We have attempted to raise this question in this paper, or at least get the debate going among dietitians. Supervision is a fundamental part of all these initiatives and does already exist in some form within the profession, as a consequence of them all. The proliferation of Specialist and Interest Groups within the BDA is testimony to the extensive and productive informal networks that have been developed to share experiences and offer support. In addition, the acceptance of CPD illustrates the importance of self-reflection and personal development. However, it is also evident that much of this supervision is informal and *ad hoc*. There is a need therefore to look at formalizing the process of supervision.

In an ideal world, clinical supervision would fulfil all the functions for which it has been developed and which have been outlined in this paper. However, introducing the concept of clinical supervision as an integral part of dietetic practice has resource implications for a profession already groaning under the weight of its workload. While Clinical Governance provides the opportunity to address the issue more formally, there remains a chronic shortage of dietitians and the situation is unlikely to be resolved in the foreseeable future. Making supervision a formal requirement for all dietitians may not be a viable option in the present climate. But should supervision at least be an integral part of working in the fields of mental health and eating disorders? There is an increasingly convincing argument to suggest that it should, based on the experience of other professional groups, and we have attempted to address this question within this paper. It is now the responsibility of the profession to debate this further. To do this, we need to agree a definition for supervision that is appropriate to dietetic practice and agree the circumstances under which supervision is implemented. Supervision in some form is here to stay but how we interpret it is the dialogue the profession needs to have.

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