Coda

It takes two

In recent months I have spent quite a lot of time thinking, teaching and writing about supervision. Like most people who have been drawn towards the subject, I have become fascinated by the way that supervision lies at the intersection of clinical knowledge and self-awareness, and by the opportunities that it offers for both technical and ethical development.

The word ‘supervision’, I have found, is not at all straightforward. If you move among mental health professionals like counsellors and psychologists, for example, you will hear them use the word constantly and fairly casually. ‘I must get some supervision on a tricky case that I’m seeing’, they say, or: ‘I’m feeling a bit stuck—would you mind giving me a bit of supervision later?’ They may be asking for an extended conversation about a case, but equally they may be wanting no more than five minutes’ chat over lunch. Used in this way, the word seems to carry no special sense of hierarchy or judgementalism, and no particular sense of formality either. Basically, supervision here means a bit of reflective time, of whatever length, to open up to new ideas.

Doctors, by contrast, often seem rather allergic to the word ‘supervision’. Until recently, we tended to avoid the word altogether as a profession, preferring more neutral terms like case discussion. Even now, many of my colleagues tell me that the idea of supervision smacks to them of something bossy and critical, and of telling people how to do their jobs—like a manager standing over someone at a supermarket till. This state of affairs is of course changing, and medics are now beginning to think of supervision in a similar way to other professions: not as having someone looking over your shoulder but as having someone looking after you. Nevertheless, my experience of teaching supervision to doctors is that, even when they manage to shake off their worries about being bossed about, they still think of supervision in terms of being given the ‘right answers’ to any problem rather than being invited to think about their work in an entirely different way—as a collaborative enterprise rather than an individualistic one.

What I have learned from mental health professionals—and now attempt to teach to doctors—is that supervision is not a teaching technique but essentially a state of mind. It is a state of mind in which both parties (supervisor and supervisee) implicitly acknowledge the limitations that arise whenever individuals see cases on their own. These limitations can affect us not just in the occasional case that seems to go badly wrong, but also in the generality of cases that seem to be going entirely right, but may only take on that appearance because we have become so excessively comfortable with ourselves.

When I see a patient by myself, for example, I am limited not just by the boundaries of my experience and my knowledge base, but also by the fact that I am who I am. I can often make up for the limitations of my experience and knowledge quite easily by using a textbook or the internet, or by the simple expedient of knocking on someone’s door and asking them a straightforward question. However, the limitations that arise from being myself are inescapable. All the questions I can think of asking the patient, and all the formulations I can think of about the case, simply cannot burst forth from the inevitable rigidities of self. Nor will any amount of training ever alter this fact. The only thing that can effectively change my thinking about any case is an encounter with another person who is able to interrogate my certainties, and perturb me into the vertiginous experience of remembering (yet again) that reality always can be seen from many different perspectives.

The task of clinical supervision, seen in this light, is not principally to explore the gaps in a colleague’s knowledge, nor to propose alternative actions. It is a more philosophical task: namely, to detect and inquire into any automatic and unexamined habits of thinking and feeling. Whether one is supervising a psychoanalyst or an orthopaedic surgeon, it involves the same fundamental processes: raising a friendly eyebrow at glibness, and interposing a penetrating question into each comfortable elision of thought.
Clinical supervision at its best can be deeply disturbing because it leads to each of us being ‘found out’—not in the trivial way we may fear, by exposing us as frauds, but in a much deeper sense. Supervision reminds us that we are partial and prejudiced human beings, who by preference will nearly always follow the mental and emotional paths we have trodden before, rather than daring to seek new ones. In that sense, giving supervision, and asking for it, may be one of the most truly scientific activities we ever undertake.

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