special articles

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Telephone peer supervision and surviving as an isolated consultant

Mentoring for newly appointed consultants in all specialties is recognised and established as offering important and essential support in the early years after appointment to a consultant post (Connor *et al*, 2000; Roberts *et al*, 2002; Waters, 2002; Dosani, 2006). In some regions this is now formalised and is in line with recommendations of the Royal College of Psychiatrists (Dean, 2002, 2003).

However, it is unclear what happens after a consultant is no longer 'newly appointed'. Does the mentoring arrangement continue with mutual agreement or does the more senior consultant need to move on to mentor further newly appointed consultants? And what about the need for ongoing support and supervision for the more senior and experienced consultants?

It is now well established that junior doctors need supervision throughout their training. Consultants supervise junior doctors and may offer supervision to other professionals, but does the need for supervision and support stop once in the consultant grade? Do senior and experienced consultants acknowledge their need for supervision and support? How does the consultant survive once mentoring has stopped and what systems and models are available to offer this ongoing supervision and support for more senior consultants?

Support systems

Support systems for psychiatrists have been described by Holloway *et al* (2000). A range of different systems are mentioned, including the importance of informal support by consultant colleagues, preferably those working in the same building. Professional support may be informal and among peers, and is an important part of ongoing practice and professional development throughout the career of a consultant (Benbow & Jolley, 1999). This informal learning occurs by the exchange of stories and clinical material during the working day (Hunter, 1991; Roberts *et al*, 2002) among a network of professionals (Eraut, 1994; Roberts *et al*, 2002).

In the Northern and Yorkshire regions during the mid-1990s, a doctors' development and mentoring network was set up to develop mentoring training for consultants. Subsequent evaluation of the scheme showed that together with training, the consultants valued the co-mentoring and the supportive network of senior doctors that the training provided. This was particularly mentioned by several consultants who had felt isolated (Connor *et al*, 2000).

With the introduction of mandatory continuing professional development (CPD) peer groups, meeting with consultant peers is now a regular occurrence, at least twice a year (Royal College of Psychiatrists, 2001). Although there is a clear agenda for these meetings, the format and structure of these CPD groups varies greatly, with some allowing more time for more informal peer group discussions of clinical and other issues and for support. They certainly result in a more formal, structured and peer-reviewed process and in personal development plans and CPD being verified and validated, but how much supervision and support do they provide for the isolated consultant?

Isolation

Consultants may be 'isolated' for a variety of reasons. These include geographical isolation (for example working as a single-handed child and adolescent consultant in a large rural area or within a sectorised service located within a community base), and the isolation that occurs within services where competition for resources, rivalry or conflict may make open and honest communication between consultant colleagues difficult. Isolation may also result, even if working in a larger centre, from work pressures and not having time for lunch or coffee breaks with consultant colleagues (Roberts *et al*, 2002). Working without consultant peers can be stressful. Day-to-day informal discussion with peers and reflection of complex clinical, team and managerial issues becomes difficult and the quality of the work may suffer.

Usually, an essential and large amount of invaluable clinical discussion and support occurs between multidisciplinary team colleagues. Staff sensitivity and staff support groups are other models of support that enable teams to deal with complex mental health and emotionally powerful feelings and conflicts in their practice (Haigh, 2000). However, consultant psychiatrists

may feel isolated within a multidisciplinary mental health team, and there may be conflict between the consultant's roles as manager and supervisor that makes open multidisciplinary team discussion difficult. Furthermore, other issues (for example certain interpersonal ones) can arise that cannot be discussed appropriately between a consultant psychiatrist and team colleagues.

There is a continuing problem with the retention and recruitment of psychiatrists and to tackle these issues there is a need to address and decrease work-related stress, ill health and burnout (Roberts, 1997; Benbow, 1998; Allen, 1999; Egerton *et al*, 2005). Consultants have a responsibility to ensure that their own needs for supervision and support are met (Roberts, 1997). Although *New Ways of Working for Psychiatrists* (Royal College of Psychiatrists, 2004; Department of Health, 2005) may go some way to addressing the pressures and stresses on psychiatrists, it does not address the issue of isolation.

Telephone and peer supervision

Peer supervision has been described in the field of psychotherapy for over 50 years (Todd & Pine, 1968; Counselman & Weber, 2004) and is established as a method for supervision of psychotherapy trainees, counsellors, supervisors, mental health professionals and other practitioners in the helping professions. The supervision may be delivered in various ways, including within a group with a supervisor or in a leaderless peer group (Hunt & Issacharoff, 1975; Hawkins & Shohet, 2000).

The potential benefits and pitfalls as well as the importance of a structure with regular review and evaluation have been described by many authors (Zorga *et al*, 2001; Campbell & Coombes, 2002; Counselman & Weber, 2004). For more senior practitioners/professionals and supervisors, one-to-one peer supervision may be organised (Hawkins & Shohet, 2000; Claveirole & Mathers, 2003). However, peer supervision is less commonly used by doctors, including psychiatrists (Arnott *et al*, 1996), nor is it described within psychiatric training.

The telephone method of supervision is normal practice for the clinical service supervision of junior doctors. It is also used for distance supervision, consultation and training of trainee counsellors, psychotherapists (Wajda-Johnston *et al*, 2005) and other health professionals in different settings (Thompson & Winter, 2003).

We describe a model of telephone peer supervision between two senior consultant psychiatrists that can enhance professional practice and provide essential supervision and support for the consultant in an isolated setting. We use a broad definition of supervision to include discussion of clinical cases, particularly focusing on the medical or psychiatric aspects, discussion of management issues, and reflection on our own responses to and mechanisms for coping with clinical and team issues. This will be further illustrated in the following account.

Personal experience of telephone peer supervision

In 2001, we set up regular supervisory telephone calls in response to the increased time we were spending outside work talking about work-related issues. We had trained together as senior registrars and in the 1990s had taken up consultant posts in isolated rural areas at opposite sides of the UK. Both of us were working in poorly resourced specialist child and adolescent mental health services (CAMHS) and were initially single-handed consultants. The supervision sessions were set up before the Royal College of Psychiatrists started a mentoring system for new consultants and before CPD and personal development plan groups became mandatory. We ring-fenced 1 hour per fortnight for these sessions, agreed the structure and subsequently included this in our job plans. These supervisory telephone calls have continued for over 5 years.

At the beginning of each session we set a prioritised agenda, including the time needed for each item. Usually two or three issues would be discussed at each session and might consist of:

- the review of a case that is particularly complex, high risk, presenting with unusual psychiatric phenomena or requiring the use of the Mental Health Act 1983
- discussion of a clinical conundrum, for example 'what antipsychotic should I use in a teenager who is very overweight, epileptic and developed galactorrhoea on the previous two antipsychotics tried?'
- difficult management, team and service issues and the consequent frustrations
- review of relevant clinical governance guidelines and best practice as linked to clinical cases
- consideration of a personal or interpersonal issue that might affect our work performance; during the course of the supervision we discussed, for example, personal bereavement, coping with illnesses and their effects on the functioning of small teams
- sharing of salient points from training events.

Although overall the experience has been positive, there have been some problems. It has been hard to entirely ring-fence the time, either because of pressure of work or feeling guilty about not using the time for patient contact. There have been some practical problems such as availability of telephone lines and confidential rooms. We also considered the effect on team members; do they see it as important that their colleague is recognising their own need for support and reflection, or is it excluding of the team that these issues are not being taken to them?

The telephone sessions have also had an effect on our pre-existing friendship. Initially the friendship gave us the feeling of safety necessary to discuss anything, but latterly the telephone sessions became our relationship and the friendship diminished.

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Conclusions

We see this method of peer telephone supervision as providing valuable and essential supervision and support that would otherwise have been hard to obtain in our isolated settings. We consider that the telephone sessions have improved and enhanced our professional practice. They have enabled us to compare services in two different rural areas with differing priorities and funding of CAMH services, but nevertheless struggling with similar problems of stretched, poorly resourced services and difficulties in recruiting and retaining trained CAMHS professionals. In times of personal difficulties it has kept us working safely.

In our opinion, peer telephone supervision should be seen as complementary to CPD peer groups, multidisciplinary discussions, mentoring networks, use of email and email forums and other forms of supervision and support, not as a substitute. It is a practical method and we would emphasise the importance of formalising and structuring the peer supervision telephone arrangements. The supervision and support may be one factor that would help prevent burnout. Pre-existing friendship is not necessary, but the peers need to be able to trust and respect one another and communicate openly without fearing criticism or feeling threatened. Review and evaluation of the arrangement is also important and any difficulties should be addressed (Hawkins & Shohet, 2000; Counselman & Weber, 2004). It could be extended for use by consultants working in different countries or continents, particularly in the current era of cheap internet telephone communications.

We would recommend that it be considered by all consultants who need supervision and support or feel isolated, for whatever reason.

Declaration of interest

None.

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