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NEEDS AND POSSIBILITIES OF SUPERVISION FOR MEDICAL STAFF FOR THEIR PROFESSIONAL WELL-BEING

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Abstract

Within this article the need and possibilities of supervision to medical staff for their professional well-being are analysed. Case of supervision to medical staff in Lithuania is discussed using critical reflection. In health care professions, same as in other helping professions, burnouts, tensions, incertitude and existential anxiety may arise among the staff. Thus, conflicts may arise over social interactions at work. Critical reflection methodology, used in this research, revealed that medical staff does not yet identify the supervision as a potential mean of their professional support. Notwithstanding, the open dialogue, enabled by the process of supervision, demonstrated the lack of collaborative culture and culture of silence in healthcare work environments. Medical staff may be anchored to the long-established attitudes and beliefs of their organization, also they may face frustrations with regard to an open dialogue on the matters of their work, since they may feel rather disempowered for making substantial changes in their work. Medical staff may also face frustrations of leaving the so-called comfort zone and helpless when facing healthcare system barriers. Within this article, the need for support to medical staff through professional supervision is highlighted. The experience of the supervision in which an equal and dialogical relation is promoted, may be extrapolated to collegial relation in the organization. Supervision may also encourage the participants to leave the victim role and to acquire a constructive voice in professional relation. Thus, the supervision, in providing room for dialogue and reflection on professional relation, may be a great an opportunity for roles' transformation of participants for constructive dialogues and organizational culture. Supervision contains the great potential to develop health system transformations through promoting dialogical professional relation and enrichment of professional identity of medical staff. Supervision might be a powerful support to medical staff in particularly critical situations such as engendered by COVID-19. The inter-institutional collaboration between associations of supervisors and medical staff is recommended, with the participation of representatives of health care institutions and universities.

KEY WORDS: supervision, professional well-being, medical staff, social interactions, healthcare barriers, health system transformations.

Anotacija

Šiame straipsnyje analizuojamas supervizijos poreikis ir poveikis medicinos darbuotojų profesinei gerovei. Supervizijos taikymas medicinos darbuotojams aptariamas pasitelkus kritinę refleksiją. Sveikatos priežiūros profesijose, kaip ir kitose pagalbos teikimo profesijose, darbuotojai dažnai pa-

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tiria perdegimo sindromą, kuris reiškiasi kaip įtampa, netikrumas, egzistencinis nerimas. Taigi dėl socialinės sąveikos specifikos šiame darbe gali kilti konfliktų. Taikyta kritinės refleksijos metodika atskleidė, kad medicinos darbuotojai supervizijos prieinamumo, kaip galimos savo profesinės paramos, neįvardija. Tačiau atviras dialogas, kurį įgalino supervizijos procesas, atskleidė, kad sveikatos priežiūros darbo aplinkoje vyrauja tylos kultūra ir trūksta bendradarbiavimo. Medicinos darbuotojai, prisirišę prie nusistovėjusių savo organizacijos nuostatų ir įsitikinimų, atviro dialogo savo darbo klausimais supervizijos metu nusivilia pasijutę bejėgiai imtis esminių pokyčių savo darbe. Be to, jie gali bijoti palikti vadinamąją komforto zoną, nes sveikatos priežiūros sistemos kliūtys lemia bejėgiškumo jausmą. Šiame straipsnyje pabrėžiamas pagalbos medicinos darbuotojams poreikis taikant profesinio konsultavimo platformą. Supervizijos, kur skatinamas lygiavertis dialogo santykis, patirtis gali būti konvertuojama į kolegialų santykį organizacijoje. Be to, supervizija gali paskatinti jos dalyvius atsisakyti aukos vaidmens, įgijus konstruktyvų balsą profesiniuose santykiuose. Taigi supervizija, suteikianti erdvę dialogui ir profesinių santykių apmąstymams, gali būti reali galimybė keisti dalyvių vaidmenis ir organizacinę kultūrą konstruktyvaus dialogo kontekste. Supervizijos potencialas vykdyti sveikatos sistemos pokyčius, puoselėjant profesinius santykius bendradarbiavimo pagrindu ir įtvirtinant medicinos darbuotojų profesinį tapatumą, didžiulis. Supervizija gali būti reikšminga pagalba medicinos darbuotojams, ypač kritinėse situacijose, pavyzdžiui, COVID-19 atveju. Rekomenduojama tarpinstitucinio vadovų ir medicinos darbuotojų asociacijų bendradarbiavimo strategija, dalyvaujant sveikatos priežiūros įstaigų ir universitetų atstovams.
PAGRINDINIAI ŽODŽIAI: supervizija, profesinė gerovė, medicinos darbuotojai, socialinė sąveika, sveikatos priežiūros kliūtys, sveikatos sistemos transformacijos.
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Introduction

Lithuanian medical professionals face particularly high professional requirements, defined in medical norms, which are prepared in accordance with the current legal acts of the Republic of Lithuania and the European Union, World Health Organization documents, respective health care study and residency programmes and other legal acts regulating personal health care activity. Medical norms specify the functions, duties, competencies, and responsibilities of medical staff. However, the circumstances under which medical professionals have to work are complicated.

The Lithuanian Medical Movement [LMM] (The LMM Encourages, 2019), representing the medical community, seeks to draw attention to the risks posed by insufficient funding for the health care system and the ongoing reform. The Junior *Doctors* Association [JDA] (Junior *Doctors*, n.d.) encourages the members themselves to initiate the change they want to see in the health care system. JDA focuses its activities on building an atmosphere of trust between doctors, patients, and policy makers. Nevertheless, the medical community still faces many unresolved issues: high workload, low pay, inefficient management model, weak systemic communication, growing emigration of medical staff. In recent years, LMM and JDA have been openly raising more and more internal problems in the healthcare system – particularly difficult working conditions for medical staff, psychological

violence not only from patients but also from the employer or colleagues, horizontal and vertical mobbing prevailing in the workplace. Painful cases of doctors' suicides and a doctor convicted for a mistake that were made public show borderline situations of medical staff. The unexpected COVID-19 coronavirus crisis only exacerbated systemic health problems and the vulnerability of medical professionals. This situation is a clear signal of a long-term crisis in the health system, when new problems are accumulating without resolving the old ones. It is evident that systemic change requires strategic intervention of professional counselling assistance.

Foreign research shows that it is especially important for medical staff to receive professional help in a timely manner when experiencing occupational stress and crisis situations such as COVID-19. The research conducted by the Chinese medical professionals Kang et al. (2020) demonstrates "that a strikingly large portion of health care providers in virus-plagued Wuhan are suffering from mental health disturbances". According to Kang et al. (2020), "among the steps needed to better prepare for future infectious disease outbreaks would be a greater investment in the mental health tools in society's medical arsenal to protect and care for future medical and nursing staff who find themselves unexpectedly on the dangerous front lines of disease response". In the United Kingdom, support groups are organized and professional help is provided to protect medical staff from the consequences of stress they experience, making it clear that they are not isolated and alone in the workplace. Gerada (2014) emphasizes that "we should adopt a more mature role that extends to self-care and putting the needs of doctors alongside the demands of patients – indeed, pulling one's own oxygen mask down first is better for doctors and better for the patients they serve". According to Greenwood (2006, 3), "counselling is highly cost-effective, helping to reduce work-related symptoms and stress and lowering sickness absence". West & Coia also raise the practical question of how doctors need to be cared for so that they can take proper care of patients, what needs to be changed in the health system so that doctors do not become disempowered within the existing hierarchical system. The scholars point out that in the United Kingdom, "organisations responsible for education and training of doctors and medical students should ensure they have an appropriate level of high-quality educational and clinical supervision provided by well-trained and compassionate supervisors" (West, Coia, 2019, 70). Many studies around the world are conducted in order to predict and define the complexities and barriers to professional practice in the medical field, they are often related to the broad context in which professionals operate. In Canada, the systemic analysis about barriers and facilitators to case management in primary care was conducted (Teper, 2019), the aspects such as family context, policy and limitation of resources, autonomy

of the professional role, practice of communication in a team, relationship with patients, limitation of time, workload, etc., were singled out.

Meanwhile, in Lithuania, the results of a study conducted by the Ministry of Health Care [MHC] (Public Consultation, 2019) still show the stigmatization of mental health of medical staff and unavailable psychological assistance. Although occupational burnout syndrome, according to Mikalauskas, Širvinskas, Macas, & Padaiga (2016), is diagnosed in one in five studying residents, and almost every tenth subject among family doctors experiences significant burnout (Styraitė & Pečeliūnienė, 2019). Such research results show that medical professionals need serious and ongoing assistance. Nevertheless, the question remains as to whether doctors would seek psychological help. A study by Montvilaitė & Antinienė (2020) shows that resident doctors would be inclined to seek professional psychological help in case of need. Professional help from the outside is especially important for medical staff, as it is not always possible to overcome difficult situations alone. Although, on the other hand, a stigmatizing approach to mental health as a risk to a medical worker's professionalism determining explicit requirements for support still prevails among medical professionals.

Providing supervision as multidimensional professional assistance to specialists in various fields is already a well-known practice in foreign countries. Now Association of National Organisations for Supervision in Europe [ANSE] (Association of National, n.d.) represents more than 8.500 qualified supervisors and coaches in the field of consulting in 17 European countries and more than 80 training institutions. Association of Supervisors in Lithuania [ASL] (Association of Supervisors, n.d.), uniting 61 professional supervisors, in 2014 became a full member of ANSE. In the different countries, which are the members of ANSE, qualified supervisors provide counselling to professionals working in a variety of fields, including medical professionals who find themselves in complicated, uncertain or stressful work situations and want to cope with them. Nevertheless, in Lithuania there is still a lack of a systematic approach to the practice of providing supervision to medical staff; supervision to medical staff is a more unitary but not a systemic phenomenon.

A review of scientific research (Walker, Clark, 1999; MacLaren, Stenhouse, Ritchie, 2016; O'Connell, Ockerby, Johnson, Smenda, Bucknall, 2013; Leffers, 2010) shows that supervision is more of a natural part of the professional activity of medical professionals working in mental health care institutions, among nursing staff and of professionals working in interprofessional teams. As Westergaard (2013, 167) notes, "there are increasing numbers of organizations whose focus is to engage and support clients to manage their lives effectively, but which are not required by mandate to provide supervision for their staff". In Lithuania, the ap-

plication of supervision to medical staff in the health care system has been studied only contextually, reviewing the need of workers of helping professions for professional support.

The complicated professional situation of medical staff indicates the need for professional assistance. This makes it possible to formulate the *problem question* of the present research: how supervision can contribute to medical staff's professional well-being through the critical reflection? The aim of the research was to recognize the need for supervision and the possibilities of providing it for medical staff for their professional well-being in the context of healthcare environment in Lithuania. It was expected that the supervision process based on reflection and dialogue would encourage participants from medical staff to name their essential professional issues and challenges and specify the needs and opportunities of the application of supervision.

1. Literature Review

Supervision for professional well-being of workers of helping professions. Daily activities of workers of helping professions involve helping other people and taking care of their physical and psychological safety, well-being, health, and often even life. Such work is specific and related to an enormous responsibility, anxiety, stress, and fatigue. Intensive and long-term communication with the client is exhausting when providing assistance. The risk of developing burnout syndrome for workers of helping professions is one of the highest. The interaction between workers of helping professions, clients and the help system can be analysed referring to the ideas of systems theory. As Parsons (1951, 25) states, "the system is a network of such relationships". According to Wagner, the worker as one person is a "mental system" operating in the "social system" of professional assistance. According to the author's statement, "mental systems are equally dependent on the social system and thus on other mental systems" (2003, 13). Consequently, workers of helping professions who experience professional burnout do not just suffer themselves. The impact of occupational burnout is much broader, including the interrelationships between the participants of the system of professional assistance and changing the system itself, its microclimate, work culture. Inadequate decisions of workers, collegial conflicts, hostile, cold relationships with clients, job dissatisfaction – these are the consequences of occupational burnout, which affect both the worker and the work organization, as well as the relationship with the client.

Professional well-being of workers of helping professions is determined by many internal and external factors: both the personal qualities of the worker him-

self/herself, his/her ability to respond to professional challenges, and the working conditions created by the organization and the policy pursued in managing change. It can be said that professional well-being works reciprocally, i.e., professional well-being of workers creates the efficiency of the functioning of the whole organization as a social system, and vice versa – a good microclimate of the organization, the focus on workers provides conditions for the development of their professional well-being. Among the elements of the system, according to Sun, Harris, & Vazire, "social interactions were robustly associated with greater well-being" (2019, 17). The social system can be seen as a complex whole, whose organization is realized under the form of reciprocal transformations between its components" (Esteves-Vasconcellos, 2015). Schickler (2005, 218), holistically investigating the nature and dimensions of well-being, points out that well-being "can be achieved and that personal work and interpersonal relationships with close others or professionals are important factors in this process". Well-being, according to Schickler (2005), consists of emotional/self, spiritual/existential, mental, physical, environmental and social elements. In the context of the present research, professional well-being can be defined as the physical and emotional well-being of an organization's employees in performing their professional role, developing professional relationships with colleagues, a manager, and clients, and feeling professional satisfaction with work and professional reward. Professional well-being is not a static thing, but a dynamic process that depends on many risk factors that take place in the personal and professional life of the worker. Not only the achievement of professional well-being is important, but also the process of maintaining and restoring it. The sources of the development of professional well-being can be various: it is the individual effort of the employee himself/herself, through being interested in the issues of concern, additional study, and so on. Another important source of the development of professional well-being is the support, evaluation, or assistance of the organization's leaders and colleagues. Supervision as professional counselling assistance can also be one of the external sources for restoring or maintaining the worker's professional well-being.

Supervision as a form of professional practice counselling can be provided to workers in various professional fields. However, supervision is especially relevant for those professions and their representatives who provide assistance to other people, because taking care of others they often lack time and energy to take care of themselves. Westergaard points to the particular importance of supervision in professions of helping people. According to the author, "supervision is a fundamental component in key fields of practice: counseling, social work, and health" (2013, 167). A number of studies show the need for and benefits of providing supervision to helping professions. MacLaren et al. (2016, 2423) emphasize that "supervi-

sion may positively influence nurses' emotion management and reduce burnout". Jovanović et al. (2016, 34) identified that the risk of occupational burnout among psychiatric trainees increases because of "long working hours, lack of supervision, and not having regular time to rest". The fact that supervision improves the well-being of medical staff working in a team is noted by O'Connell et al. According to the authors, "team supervision improved communication, enhanced working relationships, and empowered nurses to challenge existing practices, which had a positive impact on their perceived stress" (2013, 330). The practice of providing supervision to medical staff is also mentioned by the renowned psychotherapist Yalom, recalling his professional activities at Stanford Hospital in 1979: "A weekly process group, in which the staff including the medical director and the head nurse discussed their relationships with one another". According to Yalom, such a group "becomes invaluable in ameliorating staff tensions" (2017, 204).

Supervision as an assistance instrument, as a psycho-hygiene tool through various counselling methods helps to orientate in the uncertainty of the professional role, to recognize unsatisfactory collegial interrelationships, protects against fatigue and occupational burnout. For employees facing complex and existential situations of clients, supervision helps to withstand psychoemotional and physical workloads.

The setting for the organization of supervision is conventional, conditioned by many circumstances. Supervision orders can be initiated by an organization or an individual. Organizations that care for professional well-being of employees can apply for individual, team, organizational unit, or managerial supervision. The need for consultation from personal initiative arises more for individual supervision or group supervision, when specialists from one professional field but from different organizations are consulted. Supervision focuses on professional relationships, analyses work situations, structural/institutional conditions, interactions between employees who are performers of professional roles and functions, and creators of professional relationships. The aim of supervision and the content of the objective can change quickly in order to respond to the change in the situation of the organization and the need of the customer. These tasks, according to Weigand (2010, 17–18), are characterized by the fact that "they are not related to one person or one subsystem of the organization; different levels of the hierarchy are involved in the consultation process; tasks do not require a specific, traditional prepared setting, but it is necessary to develop one's own counselling architecture". The circumstances and conditions of the organization of supervision, influenced by local and global events, require a quick response, adaptive and creative approach from the supervisor.

The consultative content of supervision is characterized by the multidimensionality and specificity of the analysis. The specificity of the content is manifested in the fact that the participants of the supervision analyse the issues and topics relevant to them. However, the scope of the content of the consultative topic may expand during the supervision process. As Jansen (2010) points out, supervision takes into account relationship dynamics, professional dynamics, organizational dynamics, and field dynamics. In the case of *relationship dynamics*, supervisors (individual, group, or team) are encouraged to reflect on their experience of interaction with the client or client systems. In this interaction, supervision helps to recognize the dependence of the supervisee's actions on his/her own life history, created unrealistic aspirations and boundaries. In the case of *professional dynamics*, the main focus is on the supervisee's professional role, its fulfilment and satisfaction with this role. The personal history of the supervisee affects his/her professional role, however, the personal side in supervision is concerned only insofar as it relates to the professional role that comprises the models of personal and professional relationships. Supervision aims to expand the dysfunctional roles of the supervisee, to recognize the need for collaborative interaction with other employees of the organization. In the case of *organizational dynamics*, there is a strategic intervention in the organization as a social system, which consists of individual elements of the system – subdivisions, teams, subsystems performing management and execution functions. The main focus of supervision is on one subsystem of the system or the improvement/enhancement of the interaction of the subsystems that make up the system in order to encourage operational changes significant to the organization. In the case of *field dynamics*, the issues of availability, openness and quality assurance of the services provided by the organization to the customer system are analysed. Supervision encourages reflection on the activities of the organization's employees. The relationship between workers as service providers and the client system is analysed in order to respond to the need of the client system to receive a quality service. Critical analysis of the organization's activities helps managers or employees to understand and change the strategic direction of the organization, assessing the organization's external risk factors that determine the need and nature of its activity.

The process of supervision is based on experiential reflective models: Dewey (1933), Kolb (1984), Shon (1983), Jarvis (2001), Gibbs (1998). Referring to the structure of these reflective models, the starting point for the reflection on the activity of the participants of supervision is their professional experience. Without reflection, no area and no field or form of supervision is imaginable: "Reflection is the way of living, thinking, being, not only an action or an exercise. Reflection includes the metacognitive component (thinking about one's own thought pro-

cesses), the emotional component: consideration on personal emotional states and behavioural components; analyzing behaviour, decisions and the consequences of one's own actions in a certain context" (ECVision, 2020). The application of reflection as a conscious process of analysis in supervision encourages the transformations of the employee and at the same time of the whole organization as a system. Supervision as a reflective counselling assistance is not short-term. The time taken for the process of realizing change is significant. Therefore, continuity is important for the supervision process.

In order to create a reflective and effective process of supervision, referring to systems theory, Wagner (2003) proposes to create a new social system with the client – a communication system between the client and the counsellor, i.e. counselling system. According to the author, the new counselling system allows for a reciprocal intervention process through a structural merger and the production of joint communication. Otherwise, there is a risk that the client's system will react defensively to the intervention to maintain homeostasis. It is obvious that dialogue and building a dialogic relationship are important for supervision as a communication system. Colombero (2004) points to several ways of dialogic relationship with the other. According to him, *to be with* or *to be for*, these are the conditions that help to open up, to develop mutual trust, to feel safe, to understand the things in the world of the other that are essential to him/her and their meaning. In supervision, orientation in the current situation, according to Roos (2006), takes place in a narrative way, when supervisees are encouraged to hear an internal question that arises for them. Naming this question leads the participants of the supervision to a reflective analysis of the case of concern. Freire (2010, 79) names dialogue as a creative act, the participants of which develop capacity of "action and reflection… upon their world in order to transform it". According to the author, the word dialogue contains two dimensions: reflection and action. When a word is deprived of its dimension of action, reflection suffers and turns into verbalism, and when there is no expressed or implied action, the word becomes empty and meaningless. The union of reflection and action is evolving into a new praxis that changes the established and routine order. Critical thinking, according to Freire (2010), helps to immerse oneself in temporality, to perceive reality as a process, a change, rather than as a static entity. In supervision, a dialogic relationship helps not only to immerse oneself, but also to experience temporality, and spontaneous questions open the way to reflection on such existential themes as being, guilt, freedom, responsibility, the meaning of life. The opportunity for employees to raise issues of concern and reflect on important cases in supervision contributes to the prevention of the risk of occupational burnout and the development of professional well-being. The reflective experience of employees gained in supervision, creating an open and

trusting relationship, also encourages the development of a dialogic culture in the organization.

Clinical supervision in world practice. Although supervision is only gaining ground in the Lithuanian health care system, in global practice clinical supervision has long been applied and understood as a form of improving knowledge, abilities and skills. It is understood as a process of continuous learning and professional development based on experiential learning according to Kolb's idea (1984): personal growth, education, professional activity. "Balint groups", which are still popular in the medical professional field and have influenced the development of supervision, show the complexity of this professional field and the need for counselling/being counselled. The activity of "Balint groups" meant for doctors to discuss complex cases with patients is based on self-help, although according to Leffers (2010), in Germany, heads of institutions sometimes invest in the competence of the leader of these groups; meanwhile, a professional consultant – a supervisor – is already appearing in clinical supervision.

In various countries, various schools of supervision may have different interpretations of the concept of clinical supervision – it may be understood differently, some perceive it as surveillance or leadership, this concept may also be treated differently by heads of organizations, who may think that this is a monitoring and control mechanism. There is still a debate on this issue, and many clinical supervisors do not do without an analysis of this aspect.

Thus, information on what can be expected in clinical supervision is very important, a clinical supervision training centre of Helen & Douglas House in the UK, referring to literature sources and participants' experiences, summarizes what clinical supervision is and what we cannot call clinical supervision:

"Clinical supervision is: an exploration of the relationship between actions and feelings, a tool for professional development, a safe place, a place of learning, supportive, a place to share burdens of work, a structured framework for reflection, mutually supportive for all, open to questions and challenges, about listening and being heard, inclusive, affirming, self-driven/self-owned by participants, supportive of personal accountability.

Clinical supervision is not: a means of checking up on practice, a judgement on you or your practice, an assessment, a performance management tool, therapy (although it may be therapeutic), counselling or an opportunity to practice as a counsellor, controlled and delivered by managers, part of the reporting process, a teaching session, mentoring by the facilitator, appraisal, a "personal soap box", a place for snooping, a place for blame, a place to run down other members of the team, a place for the facilitators' agenda, a dumping ground, or place for gossiping or moaning" (Clinical Supervision Toolkit, 2015, 13).

It can be stated that clinical supervision is characterized by universal features of supervision, the supervisor is not a controller and assessor, he/she only accompanies the process, provides support to staff by asking questions for the context.

Scientific research best reflects the dynamics of the phenomenon under investigation, all the more so as the practice of counselling, science, and research interact closely in the changing concepts of clinical supervision. Clinical supervision as a form of professional support in the professional field of nursing in the current sense of the content of this service was first mentioned in 1993 (Department of Health strategic document A Vision for the Future). Extensive studies that have provided the basis for the development and creation of clinical supervision are Social Work Supervision by Munson (1979) and Supervision in Social Work by Kadushin and Harkness (1976). These authors actualized the ecological systems model of social work, which provided a basis in developing the principles and methodology of the social work supervision process. Thus, there is a constant exchange of social networks: Balint groups provided the basis for social work supervision, and the scientific empirical substantiation of social work supervision influenced the development of clinical supervision. The philosophy of social constructivism as a theory of learning (Piaget, 1929; Vygotsky, 1978; Kelly, 1963, etc.) is confirmed: new knowledge, on the basis of experience, is constructed in the context of social interaction and cultural identity.

Publications on clinical supervision first appeared in the journals: "The Counselor Education and Supervision Journal" (1961) and "The Clinical Supervisor" (1983). The sources, where a therapeutic, psychological context is predominant, are important for the scientific development of clinical supervision (Hess, 1980, 2008; Bernard Goodyear, 1992; Watkins, 1997, etc.).

To date, the methods and methodology of the clinical supervision process have been discussed, Watkins (2020), summarizing the research on clinical supervision of the last 25 years (1995–2019), reveals that the methodological problems of clinical supervision that were very relevant in the research of 1990 do not lose their relevance so far. According to the author, there is still a lack of scientific evidence and research to substantiate the impact of supervision, and models of supervision lack empirical substantiation; according to him, "evidence-based supervision appears to be more a hope and dream than supervision-based reality at present" (Watkins, 2020, 190).

Milne, Aylott, Fitzpatrick, & Ellis (2008) state that poor conceptualization of clinical supervision becomes an obstacle to further research. They have analysed 24 scientific articles to generate a summary of concepts and models, after conducting a systematic review, it was aimed at developing a research-based integral model of clinical supervision. According to the authors, clinical supervision is a more

complex phenomenon than revealed in the models constructed so far. According to them, at least 20 different interventions should be used in the clinical supervision process, the main goal of which is to promote experiential learning; the process of clinical supervision should be characterized by at least five context variables.

This concept reminds of the social work supervision model constructed by the Chinese scholar Tsui (2005). After analysing many theoretical sources of social work supervision, the author presents a comprehensive model of social work supervision, which highlights the complexity of the supervision process, interactions and circumstances. Contexts also emerge: physical, interpersonal, psychological, cultural, these contexts are also responded to by modern research on clinical supervision, which pays special attention to cultural competence.

The multicultural context in clinical supervision is explored by Kelly, King, Borders, & Jones (2020), the authors actualize the cultural competence of the clinical supervisor and other participants in supervision, the possibilities and necessity of its cultivation, ethnocultural empathy as a condition for a quality clinical supervision process.

According to Hawkins (1997), a model of five levels of culture can be observed in the supervision process, in which each level influences the level beneath; these are: 1) artefacts: rituals, symbols, art, buildings, policies, etc.; 2) behaviour: patterns of relating and behaving, the cultural norms; 3) mindsets: ways of seeing the world and framing experience; 4) emotional ground: patterns of feeling that shape the making of meaning; 5) motivational roots: fundamental aspirations that drive choices.

Many clinical supervision studies highlight special attention to the cultural context and the counselling process, in which new knowledge is constructed through active operation. Here, social interaction, in which communication, cooperation, and sharing without losing one's authenticity take place, becomes a very important component. Again, the question of personality and continuous learning/lifelong learning arises. Argyle (2017), substantiating social interaction in the context of social psychology, focuses on communication – bodily, verbal and non-verbal, giving a special meaning to the cultural environment. These communicative aspects form the basis of empowerment and self-empowerment in clinical supervision as well.

Guiffrida (2015) explores the process of clinical supervision from a constructivist perspective, focusing support and attention on the diversity of the experiences of the client, supervisee, and supervisor, discusses the supervisor's cultural competence in the context of theoretical depth and practical benefit. The efficiency of the supervision process, benefits for the employee and the organization are also studied, special attention is paid to the process of clinical supervision practice.

Burnes & Manese (2019) prepared a scientific case study that actualizes cultural competence in the work of doctors; cultural dynamics are revealed through the prism of social interaction in a multicultural system. The authors touch on the issue of relationship through aspects such as ethical law and regulation, feedback and evaluation, and present a variety of interventions in the clinical supervision process in response to a specific case. It can be stated that special attention is also paid to the personality of the clinical supervisor, its cultivation; it is possible to identify the following elements of the internal structure of the personality named by Jovaiša (2009), to which the researchers' attention is directed: activity, character, abilities, motivation.

The issue of a clinical supervisor's competence is extended by Daniel, Borders, and Willse (2015), exploring the roles of supervisors in the context of mindfulness. Mindfulness as a construct is important both in the process of supervisor training and in practice, mastery of mindfulness elevates the process of supervision to a specific level, where simplicity and mindfulness can help to establish a therapeutic relationship in clinical supervision.

It is proposed to divide the functions of clinical supervision according to the model of Proctor (1988) (well known in the field of social work supervision): normative function – development and review of professional standards; formative function – application of reflective methods in linking theory and practice; restorative function – support focused on self-development.

The field of medicine is characterized by a complex systemic structure, this feature makes the system special, poses new challenges for the development, organization, process, and content of supervision as a form of professional relationship counselling. It also invites to specialize – clinical supervision works with doctors and nurses of various specializations, there are also different levels of organizational structure.

It is likely that the international experience of clinical supervision as a science and practice will influence the development and breakthrough of supervision in the Lithuanian health care system.

2. Materials and Methods

To explore the need and possibilities of supervision for the well-being of medical staff, critical reflection as a research method, in the way that was elaborated by Fook (2011), was employed. Fook defines critical reflection as an "overall process of learning from experience, with the express aim of improving professional practice" (2011, 56). Fook observes that the process of critical reflection enables "the deeper and more complex understanding of practice <…> in which the practition-

ers themselves often cannot initially express" (2011, 55). In that sense, the critical reflection is particularly relevant for the analysis of supervision of healthcare workers, since, as literature review demonstrates, they face very complex professional realities which usually do not leave time and space for their reflection. Fook defines critical reflection "as a way of learning from and reworking experience. Participants begin by presenting a story of their experience which they believe is crucial to their learning about their professional practice" (2011, 56). Critical reflection is a process in which the dialogue between participants is promoted and "facilitated by an appropriate climate for open learning and risk-talking to support trying on new, multiple or even opposing ideas" (2011, 57). According to Fook, "the process might be seen as a way of connecting emotions with practical experiences; a making meaning of experience; excavating the fundamental values in practice" (2011, 62).

The case of supervision for medical staff for their well-being using critical reflection is presented within this article. Research was carried out in Lithuania, in a primary health care institution serving over 40,000 people in the central region. The institution employs more than 300 staff, including 70 doctors and 160 nursing professionals. In the supervision process, there were 14 participants, including the representatives of the institution's administration (head of the institution, deputy head for methodical work, deputy head for clinical work, head of internal audit team, chief nursing administrator, head of department), senior specialists of four different units, staff specialist, project coordinator, person responsible for supervision of the economic unit and person responsible for public relations. The length of work experience of the participants in the field of health care is from 6 to 43 years. In accordance with the requirements of confidentiality, the names and gender of the participants are not named.

The supervision process took place in 2019, consisted of 8 sessions and lasted 5 months. At the end of the process, the participants were asked to respond voluntarily to the questions of the written survey. The participants were asked open-ended questions: 1) describe the meaning of your participation in this supervision for you personally; 2) what has changed in your work environment (relationships, attitudes, work with clients, etc.) during the supervision period? 3) what was difficult about this supervision? 4) would you consider supervision to be an appropriate way to solve problems in your work environment? 5) would you recommend supervision to your fellow medical professionals? If so, what do you think would be the benefits of supervision for healthcare workers? Nine questionnaires were completed. Based on the responses from the participants, the supervision process that has taken place is reviewed below. Each participant has his/her own code (A, B, C, D, E, F, G, H, I) for research purposes, which is indicated when quoting the

participants' answers in the empirical part of the article. However, during the written survey, the participants were not asked to indicate their positions, so as not to violate the principle of confidentiality, as the positions would allow the respondent to be easily identified.

3. Results

The supervisor's critical reflection on supervision:

The context of supervision. The supervision process took place in a primary health care institution, which ran a project meant to strengthen the mental health and well-being of medical staff at work. It should be noted that all the activities carried out in this project were aimed at improving the mental health namely of employees (medical professionals): employees learned various stress management techniques, attentive mindfulness, relaxation practices. The institution had also conducted an internal investigation about the stress experienced by employees at work. Supervision was envisaged as part of this project and took place as the last, final activity of the project. Thus, the context in which supervision began was in line with the essence of supervision – it was associated with the possibility of improving the mental health and well-being of employees at work. It seemed like a truly professional approach: those who care about the health of others try to take care of their own mental and emotional well-being.

It was not entirely favourable that after a lot of training in mastering techniques and methods helping to improve personal mental, physical, and emotional well-being, the initial expectation for supervision was similar – to quickly master some method that will allow to quickly improve well-being. It is also important that after the previous trainings, the participants in the supervision also hoped for relaxation, a fun stay with their colleagues. Therefore, the expectations of the participants expressed during the first session emphasized the good mood, well-being, the possibility to take a short break from work. None of the participants had previous experience of supervision. At the beginning of the supervision process, the supervision itself, its purpose, features, responsibilities in it – what seemed important for the participants to have a clearer idea of what to expect or what not to expect from supervision – were presented.

The setting of supervision. By coordinating the format of supervision, there was a desire expressed to hold weekly sessions just so that everything planned would happen faster. However, after discussing whether such a pace is possible in an institution where all employees have a fairly strict work schedule, or whether such an intensity will be acceptable to the participants themselves, it was agreed to

work at a more moderate pace, meeting every two weeks. Eight supervisory meetings were held, each lasting 3 hours, during staff working hours.

The order was focused on the supervision of a group of employees of the institution. The first supervision session was attended by 14 participants: representatives of the institution's administration (head of the institution, deputies, heads of departments), senior specialists, staff specialist, project coordinator, person responsible for the supervision of the economic unit and person responsible for public relations. This composition of the group has already been envisaged in advance by the customers, justifying that supervision should involve employees with various responsibilities, making decisions in the institution and often having to cooperate in solving work tasks. However, both the composition of the participants and the issues raised in the supervision and the topics covered show that there was more organization than group supervision: the topics of communication, management, employee competence, mutual support, leadership quality were examined. In the future, when starting work in medical supervision, it is important to discuss the order and expectations very clearly, discuss it directly with the customers, as well as pay more attention to the presentation of the supervision itself and its format (group size, meeting frequency, place of supervision, etc.) and so on because for a medical audience, this is not an ordinary experience.

The process of supervision. Supervision was started by 14 participants in the first meeting, 11 participants continued the process from the third meeting to the end (8 sessions). The uneven dynamics of the group had an impact on the overall work atmosphere. After the first meeting, two participants withdrew, reporting only to the direct manager, but did not report anything to the group. One of the arguments was that they had no problems to deal with in that group. The head of the institution was present at the first and third meetings, but did not participate in the rest of the supervision process any more and did not inform anyone about it. It also revealed the general culture of the organization: to inform about one's decisions or changes only those who are the undisputed authority. The absence of important members of the organization became a cause of frustration for other members of the group. Eleven participants continued the process until the end. However, observations have been made on several occasions about the postponement of work due to supervisions, about the fact that it is not quite clear how they will apply the experience of supervision in their work, thus, there was a kind of underestimation of supervision and regret for the time allocated to it. However, in the second half of the process, more of the participants' own insights and understanding of the possibilities offered by supervision emerged. For me, as a supervisor, such dynamics did not allow to "predict" possible topics that would be relevant in the group, because the change of participants encouraged me to react to other topics again and

again. It also allowed the thematization of the participants' growing dissatisfaction with the process and relating it to the parallels in professional life: change, lack of opportunities to constantly reach the manager, and so on.

Cultural context of organizational cooperation. Most of the supervisees accumulated most of their work experience namely in the same institution where they still work. Consequently, these are long-term employees of the organization. The long work experience had various "reflections" during the meetings: from positive observations that "we talk to each other", "everything is fine with our team" to negative moods: "it has always been so and nothing can be changed", "hopeless", "we tried, it does not work", "I will keep working as I used to".

Questions of the purpose and content of supervision. It took a while for the participants to realize that supervision is not training, and that they bring the content to supervision themselves – their cases, situations, problems. To the initial question of what they would like to talk about at the meeting, the frequent reactions were that "I don't have my own question, but I would like to listen to the colleagues". When the expectation that the supervisor would teach, direct, or explain was not met, doubts arose about the meaning of supervision.

Transformations of topics raised in supervision. The participants of supervision raised the following topics relevant to them: negative emotions among employees (anger, hostility, claims, dissatisfaction); communication problems (not hearing each other, not understanding, the need to hear each other and be heard in meetings, 5-minutes); the need for proper information ("timely, clear, direct and not through rumours"); the need for clarity and prioritization ("not to be in a constant state of "firefighting""); clear roles and responsibilities and an equal understanding of them by everyone; high pace of work ("adequate time is needed to complete a given task, i.e., "at a normal pace""); distribution of work according to the employee's competence; the need for feedback ("express it immediately after the completed task to the person who performed it"); the need for a respectful relationship ("to express one's opinion properly, without offending each other"), the issues of team building, mutual support, mutual assistance were identified as well. When the participants noticed that supervision also provides an opportunity to learn something, the following experiences were named: "not to be afraid to ask", "not to be afraid to name your situation", "to communicate without tension", "to protect the limits of your responsibilities".

The topic of leadership was mentioned in at least five of the meetings, the need for a clear, structured, respectful relationship from the manager's side was constantly expressed. When the manager stopped participating in the supervisions (since the third meeting), the disappointment was expressed that the main addressee as if was not present. This has led to the examination of the topics of

helplessness and power, the relationship with authority, the declared and actually applied modes of action. The analysis of helplessness, surrender to circumstances, the position that "nothing depends on me" led to a turning point – the topic of "victim": how does it happen that I feel like a victim on whom nothing depends? What can I do to avoid being a victim? This topic encouraged the participants to see themselves in relation to everything that causes tensions and dissatisfaction in their work, themselves as a provider of feedback, as a creator of one or another relationship and significantly changed the direction of supervision, the atmosphere in the group, and the involvement of the participants themselves.

Thus, the supervision process highlighted the topics that revealed a wide and varied range of problems faced by healthcare workers in their professional activity: hierarchical relationships, the importance of authority, fear of disobedience to authority, even if it contradicts regulated agreements, attempts to "protect oneself" with job descriptions, i.e., with something that legally protects the employee; ineffective communication; fear of openness determined by fear of consequences; tolerance for disrespectful behaviour; fear of mistakes; position of adaptation, waiting; feeling of inequality in relation to clients (patients). The topics raised show that the aspects of structure, leadership and cooperation, which cover the various levels of the organisation's activities, are important to the participants.

Critical reflection of supervisees on the process of supervision:

The participants answered one of the questions of the written survey – *what has changed in your work environment (relationships, attitudes, work with clients, etc.) during the supervision period?*: "I visually saw and heard what we were "silent" about" (C); "I realized that you don't always have to be a "victim", you can also be a "leader-guide"" (A); "I try to provide timely and specific information to colleagues, and I want the same from them" (B); "I realized that there is no need to rush to underestimate yourself, no need to be afraid to express your opinion" (G); "I realized that if you want changes you must start from yourself" (I); "we started to communicate more openly with each other, I gained the courage to talk about my feelings" (E); "the "masks" are not stuck and we can take them off, as long as we want and are not afraid to risk being ourselves. This requires a safe working environment" (C); "attitudes towards work have changed, I have thrown away the states of a forced victim, I do not take unfounded accusations against myself" (H); "I feel less stress, fear, anxiety when talking to the manager, I accept everything not personally, I try to express and defend my opinion" (I). There were also more moderate observations: "when the patient is always right and the manager is always right, it is difficult not to be a victim" (D). Nevertheless, knowing that this was the first experience of the participants in supervision, these realized moments show that supervision can lead to change, albeit a small one, that it is possible.

The fact that it is difficult for medical professionals to reflect, that they are accustomed to striving for a tangible, measurable result in their professional activity was shown by the constantly expressed question: how is what happens in supervision applied in practice, at work? "Personally, I don't really understand if I've learned anything new or if I can apply it in my work" (A), "it is difficult to understand how to apply in practice, in everyday life what I have experienced or mastered during supervision" (B). It was also difficult for the participants to talk about themselves, their personal experiences, it was difficult to "understand what I personally need from that supervision" (E); "it is difficult to talk about myself" (H); difficult to "talk openly about the fears faced and stress at work" (I); "to speak openly, not to gossip about other colleagues, to state clearly what we expect" (D). It was new, and it took time to realize that talking about one's feelings and well-being could be effective not only in achieving emotional relief, but also in finding solutions. It is likely that by deepening this experience of self-reflection, by creating a safe environment for sharing, medical professionals would see supervision as a tool that provides more practical benefits for their work, emotional well-being, and professional well-being.

The participants were asked *would you consider supervision to be an appropriate way to solve problems arising in your work environment?* "In some cases, yes, when you don't have to be afraid to name your situation" (A); "I think so, because we would be able to avoid unnecessary tension, learn to listen and hear colleagues, and be listened to and heard ourselves. Appropriate feedback would be provided, especially communicating, sharing information" (B); "Yes, if the right conditions were established and everyone believed that problem solving depends on us ourselves" (C); "There is still room to grow to that. I think that <...> it would be complicated" (D). "Partly yes..." (E); "All ways of solving are appropriate" (F); "Yes, definitely so. In the department, which employs about 20 people, I think there could be supervisions for two groups. <...> this would help to deal positively with all issues without intrigue and anger" (G); "Yes. To this day, the problems are not even named..." (H); "And yes, and no. Yes: raising the problem and addressing it would bear fruit – it would not happen again. No: the problems that arise depend not only on me and I can't control the ways to solve it" (I). Thus, despite new experience, the purpose of which was sometimes difficult to understand, the participants see the point of solving work problems in supervision.

They were also asked *would you recommend supervision to fellow medical professionals*? If so, *what do you think would be the benefits of supervision for healthcare workers?* Supervised medical staff singled out: "I don't know, I would advise to those who are open. It would be difficult for those who are closed" (A). "Yes. To learn understanding, respect and collegiality in working relationships, first and

foremost starting to change yourself" (B). "Yes, it would be the most useful for breaking up old hierarchical relationships, creating a new leadership culture, evaluating every specialist, not just doctors, building a respectful relationship, improving the quality of health care, because an employee, who feels well, works better" (C). "To start solving problems, to help the medical professional not to feel like a victim. Maybe mobbing would be reduced" (D). "Yes, it is always worth a try" (E). "Yes, I believe that the more information is received and used properly, the greater the added value for the institution. It is also beneficial that the employee sharing his/her experience with colleagues becomes loyal" (F). "Yes. Medical professionals at work already experience a lot of negative emotions, face the tension caused by communication with some patients" (G). "Yes, I would recommend it. To raise and name problems in work relations, to define ways to solve those problems, what actions need to be taken so that the work environment does not "heat up"" (H). "This would be the sharing of collegial thoughts, opinions, problems, ideas outside the work environment, which could be applied in the work environment. In this case, it is an unavoidable necessity that all the heads of the institution participate in the supervision" (I). The fact that the participants express specific insights into what should happen in supervision, what should be the composition of the participants, what expectations are associated with supervision (building a new, equal relationship) shows that the essence of supervision was understood and acceptable.

Supervisor's self-reflection:

The supervision process that took place was interesting for me as a supervisor in that I had the opportunity to work in a new professional field, to delve into problems of a different nature than before. It was useful to observe the transformation of the group from the participants' expectation of an easy, almost playful process, into resentment when it becomes unclear what is happening and why, into the realization that it is all related to their own participation, asking questions, expanding the boundaries of openness and finally the parallels with the participants' professional well-being in their daily work. This allowed to understand how wavy the supervision process can be and how important it is to pay enough attention to the preliminary presentation of supervision and contract when working with medical staff. If supervision of the organization is envisaged, not only the main customer (organizer of supervision) but also the heads of the institution and departments should be involved in concluding the contract. The experience gained has also confirmed that the supervisor's posture – i.e. thematization of everything that happens during the process, "showing" to the participants themselves, etc. – allows confrontation and negative atmosphere to be transformed into constructive communication. It is these moments of perception of the situation, self-seeing, "longing" for a different relationship that were mentioned by the participants as the most valuable in the

process of supervision. This is the result of supervision that is difficult to predict or "promise" at the beginning. The fact that most participants saw the meaning of supervision and would recommend it to their colleagues to try was the answer to me that supervision is one of the ways to raise the professional awareness of medical staff, strengthen their professional identity, and create professional well-being.

4. Discussion

The research conducted has shown that the process of supervision based on reflection and dialogue (Roos, 2006) can not only encourage the participants of medical staff to speak about the key issues and challenges of their professional activity, which indicates the systemic complexity of their professional situation and the need for supervision. The critical reflection of the supervisees revealed even more. The fact that during the period of supervision, medical staff managed to move from silence to a culture of constructive communication, broaden the vision of their professional identity, reduce the prevailing emotional tension in the performance of their professional role – this suggests that supervision contributes to the development of the professional well-being of medical professionals.

According to the model of Jansen (2010), referring to the research conducted, the current content of the counselling need for supervision for medical staff can be detailed by raising such reflective questions/topics: in the *field dynamics* – what is (not) happening in the field of health care recently, COVId-19 period – issues of medical professionals' responsibilities, workload, remuneration, teamwork, provision with work equipment; in the *professional dynamics* – what medical professionals are today – who and how become medical professionals, the attractiveness of the profession, the need for it and evaluation in society, changes in the legal framework in the doctor-patient relationship, the impact of personal and professional conflicts on the professional role, the development of professional identity; in the *organizational dynamics* – what is (not) happening in a particular healthcare organization – structural changes, evaluation processes (audit), administration and staff turnover, changes in quality control; in the *relationship dynamics* – how the transfer of information takes/does not take place, the distribution of responsibilities, hierarchical or collegial relations, the relationship of errors/consequences – support or punishment.

However, when aiming to specify the needs and possibilities of the application of supervision, limitations are visible. It would be difficult to hope that, on personal initiative, medical professionals who face heavy workloads, physical and emotional fatigue, would waste personal time and financial resources on supervision. Especially without having personal experience of the benefits of supervision.

Meanwhile, supervision as an external form of professional assistance to medical professionals in the healthcare system is still not formally and structurally validated. Changes in the healthcare policies are needed to make supervision available for medical staff (Kotkas, 2018).

5. Conclusions and recommendations

The research conducted shows that supervision is beneficial for people in different helping professions, including medical professionals. Supervision is a little-known service for Lithuanian health care workers – doctors, nurses, managers and other medical staff; there is a lack of research and educational activities in this area. The international experience of clinical supervision is of special/extrapolative significance for the development of supervision in Lithuania.

Summarizing the research conducted, the obvious need for supervision for Lithuanian medical staff can be seen. The research allowed to identify systemic healthcare barriers of communication among the medical staff. The research has shown that medical staff have an enormous need to express their professional experiences including emotional experiences and the need for reciprocal dialogue. The research has shown that supervision that promotes critical reflection can be a relevant and suitable method for this purpose. Supervision allows participants to start speaking and to give meaning to their experiences and to move from a culture of silence to a culture of constructive dialogue. Thus, research within this article demonstrates the strong possibility of supervision to contribute to the transformation of organizational culture in healthcare system. The experience of continuous supervision would help medical professionals to accept supervision as a tool that strengthens their professional well-being.

Based on the research, the article provides specific practical recommendations – to conclude cooperation agreements between the Association of Supervisors in Lithuania [ASL], Lithuanian universities, healthcare system institutions, organizations representing the medical community. The purpose of these agreements is to: a) ensure the availability of supervision for medical staff for their professional well-being, as a permanent external form of professional assistance; b) to promote the dissemination of supervision and the development of practice in the medical community; c) to invite supervisors, researchers and practitioners to collaborate in research in the field of the application of supervision. After the implementation of these activities in practice, the transformation effect of the healthcare system is expected. These recommendations might be extrapolated to other contexts, including European States, in providing cooperative systems between universities, professional medical organizations and healthcare system institutions and Associa-

tion of National Organizations for Supervision in Europe [ANSE]. According to the president of ANSE, Roos (2018), "boundary crossing" provides "sustainable cooperation between the many peoples of Europe".

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