Introduction

Supervision is a negotiated relationship between the supervisor and the supervisee. The purpose of supervision is to develop the supervisee but the ultimate expected outcome is the highest quality of service to the client. Thus, supervision does not only serve educational purposes, but also carries the aim of ensuring that the service is up to standard, through its support and management functions. Corresponding to these functions, supervision involves formative, restorative and normative tasks. Another classification divides supervisory interventions into two categories: authoritative and facilitative. Authoritative interventions can be prescriptive (offering advice or suggestions), informative (providing information) or confronting (challenging the supervisee’s behaviour or beliefs), while facilitative interventions can be cathartic (facilitating the expression of emotions), catalytic (encouraging self-exploration and problem solving) or supportive (enhancing the supervisee’s self-worth).

Supervisory interventions are not just the work of the supervisor. For supervision to be effective, the supervisor must be knowledgeable, experienced and supportive, and must be able to maintain a trusting relationship with the supervisee. The supervisee, nonetheless, is also responsible for his/her own development, support and assessment. The supervisee must be able to reflect and learn from his/her work, share with the supervisor his/her difficulties and emotional stress, and examine his/her own shortcomings and blind spots.

Clinical supervision in palliative care

It has been said that a hospice is a nice place with nice people. This might create problems in clinical supervision. This is especially so in the initial period, when the supervisee often lacks confidence, has a highly positive view of the supervisor and accepts too readily what the supervisor says. Eagerness to please each other may also hinder the supervisor’s critical appraisal of the supervisee’s progress.

Palliative care emphasizes on a holistic approach, looking after not only the physical aspect, but also psychological, social and spiritual issues of the patients and their families. On entering the palliative care training program, the supervisee often is, however, used to the biomedical paradigm. The clash between the biomedical and the biopsychosocial paradigm may bring about anxiety and hostility. Despite experience in the biopsychosocial approach, there is a possibility that the supervisor might at times confuse supervision with counselling of patients, which might result in unnecessary intrusion into the personal life of the supervisee. Moreover, the supervisor might sometimes find it difficult to be an assessor as well as a supporter of the supervisee, which might impair their empathic interactions.

Dealing with life and death, palliative care requires a lot of experiential learning. Having had a concrete experience, the learner interprets his/her observation and develops a theory or a conceptual framework, with which he/she then experiments. Subsequently the skills and knowledge validated through experimentation would be internalized to become his/her own standard practice. Interpretation of an experience is influenced by the values, assumptions and prejudices of the learner. Hence, to appropriately interpret, and subsequently learn from an experience, the learner has to be aware of his/her own values and biases. It would thus be difficult for a palliative care trainee that lacks self-awareness to gain from experiential learning. People with different life experiences, and hence different values and assumptions would interpret a situation differently. Differences between the life...