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A New Model for Doctor Development

Frischer, Josef; Scheinberg, Dr. Sari

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Josef Frischer
&
Sari Scheinberg

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Relationship based Learning
– A New Model for Doctor Development

Josef Frischer, Aalborg University, Denmark and
Dr. Sari Scheinberg, Energy Lab, Sweden

Content

Abstract

The master-apprentice approach for the development of new doctors has been the standard procedure for their learning for decades- or has it? An investigation of doctors in Sweden has shown that the majority of doctors have not received adequate to any supervision during their development. Their working climate for learning and teaching is extremely stressed and production oriented. There is little time for reflection and learning. This climate has created a context whereby sharing mistakes, concerns, and problems are taboo. And the transfer of knowledge, skills and attitudes has not been effective. This stress is causing doctors to feel inadequate and complacent. In Sweden the National Board for Health and Welfare requires

doctors to have formal supervision however the hospitals are not prioritizing it and have no standard procedures for it.
It is within this context that a new program was created to improve the learning process between senior doctors and their interns and residents. This program – Relationship based Supervision – builds on an action learning and self reflective approach to support senior doctors to create their own systematic and structured learning strategies and processes.
The models for supervision and for learning used in this program will be presented and analyzed in relation to organisation and learning theory. In addition, an analysis of the experiences and reflections of the 50 doctors who have participated in this new program and how they applied these models in their own work and defined relationships with their supervisees will be presented.
Some of the main findings include that all the doctors experienced a change in their own attitudes and behavior. They have developed a systematic and conscious approach to working with their younger doctors. And have learned that reflection and relationship are key to support the learning process and reconfirmed that the masters apprentice approach is still critical for training doctors. Many of the doctors have also initiated changes in their organisation needed to support the demands of the supervision.

I Background and Problem definition

1. Why is supervision needed for Doctors competence development

Although research is currently showing that supervision (Frischer, Scheinberg, Glumoff,) is a critical factor in the development of most professional groups, there are only a handful of professions that have actually instituted supervision or a 'master-apprentice' relationship as a formal part of the development process. Studying and preparing to become a medical doctor is one of the oldest and fortunate professions that have included this method of learning – of transferring theory into practice from a master to an apprentice - into the development process.
In the medical profession, as in most professions, much of the knowledge and competence that needs to be transferred between colleagues is not always explicit and easily transferred. So much of what is known, is often hidden, sitting in our fingertips or intuition. Accessing and transferring such quiet or tacit knowledge is always a challenge. However, amongst the many methods used to enhance learning, the master-apprentice relation supported by supervision has proven itself as very successful way.

2. Formal laws and demands – requiring supervision

In addition to being a tradition and practical solution for learning, supervision is also being demanded by law. For example, the National Board for Health and Welfare (which oversees the standards and practices of medical services in Sweden) passed legislation[1] in 1996 that established that supervision must be given to doctors during the different periods of their competence development. They specifically named that doctors needed to receive supervision during their internship period, and during their residency period. The legislation also states that those persons supervising should be specialists in the relevant field. Additional legislation was passed in 1999, where it was stated[2] – that supervisors have to be qualified to be a supervisor.

[1] SOSFS 1996:27
[2] SOSFS 1999:5

3. Previous studies done on Supervision in Hallands Region

Many laws and theories give good reason to promote supervision as a key method for learning in the medical profession, however it has been found in a number of studies in Sweden during the past few years that supervision while being required and considered important is neither given regularly nor, if given, is not so effective or satisfying. For example, one study conducted in 2004, identified that while most doctors in training do receive a supervisor – it is in name only, with nearly no relationship developed, and nearly none of the supervising doctors with any training to be supervisors. Another study[3] conducted in 2003 on residents working in the county showed that while 90% perceive supervision as very important, 70% of the doctors surveyed said that the supervision they receive does not fulfill expectations either completely or partially. And yet another study[4] conducted in March 2004, on interns working in a major hospital in this same county showed that only 40% of the doctors thought that the supervision they are receiving is useful and two thirds stated that they are not satisfied with their supervisors. And in a fourth study conducted in Feb.2004 on supervision within one of the major clinics in the Hospital showed that: it was not clear what was meant by supervision and what the supervisor needs to do. Many suggestions were collected during these few studies, with recommendations for creating clearer definitions and planning and structures for supervision.

4. History of supervision training – and the experience of our training program

It was in this context that a new supervision training program was introduced into this county in 1999. Until 1999, the county did not offer supervision training for 2 years, and our analysis found that only approximately 36 doctors out of the possible 700 doctors (who currently work in this county) have received supervision training during the past 4 years. A logical question to raise here is of course – 'why, if there is both a demand and a need for supervision training have so few doctors been trained as supervisors'? One answer we have found from our analysis is that while supervision has been a long tradition in the medical profession and is theoretically justified as enhancing the learning process, practice is another thing. The working culture currently dominating Swedish work places is very stressful, with an emphasis on efficiency and effectiveness. As a result, little time is available for meeting and supervising. Little value is seen in supervision. The unspoken attitude from a number of senior doctors is 'if we survived without supervision – then you can too.' In addition, our analysis has also shown that the overriding cost cutting orientation of the health care administration has put supervision training as a low priority for investment. Hence, limiting the delivery of the course both in frequency as well as in length of time.

Regardless of these difficult circumstances, the supervision program – Relationship based Supervision – has struggled to work against the current culture, and to stand firm and defend the need for supervision and thus supervision training for Doctors in this county. This program also promotes a way of working that emphasizes a conscious and systematic way of working and an approach that depends on relationships for its success.

5. A brief review of the Relationship based supervision

The 'Relationship Based Supervision training program' followed a design that mirrored the learning cycle concepts taught, whereby participants were given a chance to 'learn-experiment-reflect and then integrate the learning into their experience'. The design followed

[3] A. Berlin *Supervision during Residents Training*, February 2003
[4] C. Rydberg, *Evaluation of Supervision for Interns*, March 2004

the following process: Three days of training, where the participants learned new concepts and explored their own experiences and attitudes with supervision. Three half-day supervision sessions (a month apart) in a small group with other Doctors in the class. The course ended with a 2-day training session followed by a half-day supervision meeting.

II Theory

Learning
Knowledge/competence can be acquired in different ways. For example when interns/residents studies theoretical literature, conducts own experiments or learns through dialogue and discussions both at seminars with professional specialists and fellow interns/residents (codified knowledge) (Lewin, 1943) However, a large part of professional knowledge/competences required by the interns/residents, like experiences, skills and attitudes, are "tacit" and therefore hidden in skilled professional specialists (Polanyi, 1966). These knowledge/competences cannot be easily codified and transferred from one individual to another and one way to its transferal, is to develop/enhance a relationship based interaction between the skilled professional (master) and the intern/resident (apprentice).

Master -Apprenticeship
The master-apprentice relationship has a potential of conveying both codified and tacit knowledge. Here, learning takes place in the interaction between the parties and through different mechanisms, including words in the form of instructions and feedback, or through opportunities for the apprentice in observing the master. By definition, the skilled professional, in a master-apprentice relationship, is supposed to master the subject area. However, the master is most often only able to articulate part of his/her competences, while other parts, which over years of experience, has become so much a part of himself that he doesn't reflect upon it (Polanyi, 1966). There are however, a number of ways of making tacit knowledge more explicit and visible between the master and apprentice. One way is to ask the master to reflect upon his/her way of performing a task, including both motor and thought steps, i.e. to make the master articulate on knowledge that otherwise would remain hidden. Another way is to let the apprentice study the master's work process and ask questions, which may also reveal deeper knowledge There is also the possibility that the apprentice by participating in the work process, doing the same things as the master, gradually will develop own competence through a process, which to a large extent is tacit in nature (Lave and Wenger, 1991). In addition to the apprentice learning from the master, the master has the possibility to learn from or with the apprentice or from the process as well (Elson, 1989). Hence, by being part of this relation the apprentice can also learn to learn from the master. However, ultimately these learning processes aim at making the apprentice develop an in-depth competence within his/her specific area, which over time may become deeper than that of the master's competence.

The RELEMO model
This model (Frischer, Scheinberg and Alänge, 2000) presented in figure 1, presents some of the components needed in establishing the relationship between 2 persons, joined together due to their mutual need to transfer and develop competence. At the center of this relation, is the concept of the Learning Alliance. Bordin (1979) proposed that the alliance between a person who wants to learn and another person, who offers knowledge, is one of the keys, if not *the* key to learning. At the core of the learning alliance, is the notion of mutuality in terms of the development of a mutual platform for the supervisor and apprentice to work on.

Contracting

The learning alliance can be manifested in a contract that includes mutual agreement on goals, on tasks, and on process to reach the goals (Clarkson, 1996). Both the supervisor and the apprentice need to express their needs and demands on the cooperation. By making each party's expectations clear, as well as making the process leading to the end of the education visible for both parties, a mutual agreement (the contract) can be established between the supervisor and the apprentice. However, the quality and content of relationships can vary considerably, which has implications on the learning process.

Quality of relationship

Relationships can be qualitatively characterized as instrumental, affective or ethical (Kanter, 1967) Instrumental relationships focus solely on the task. Affective relationships include the parties expressing what they like and dislike. Ethical based relations, include expressions of values and views on what is good, bad, righteous or wrong- A master-apprentice relationship of a pure instrumental nature is lacking the potential for transferring more subtle and tacit components of competence. The more affective and ethical dimensions that are included into the relationship, the more of tacit knowledge has a potential of being communicated (Scheinberg, 1998). However, a relationship including affective and ethical dimensions need considerable time to develop, as the parties need to develop a deeper understanding of each other.

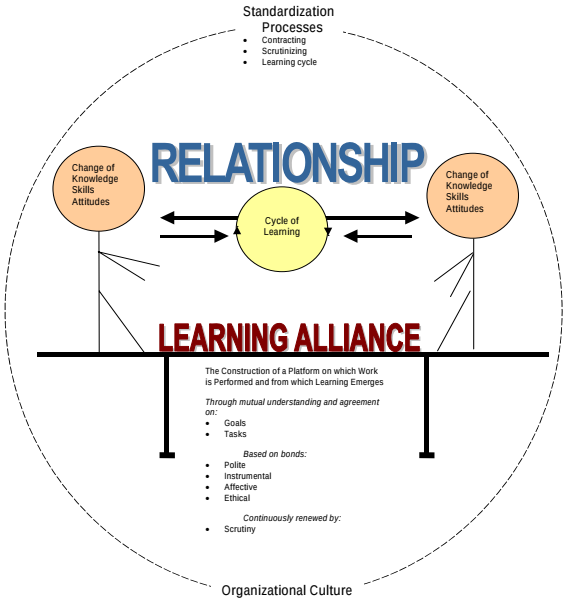

Figure 1: RELEMO – The Relational Learning Model
Frischer, Scheinberg and Alänge)

Mutuality

The relative balance between the parties in a learning alliance can vary considerably, depending on the natural inclinations of the supervisor and the apprentice, as well as on the specific process for establishing a platform. Typically, the balance also varies over time, where the apprentice gradually assumes a more prominent role, taking over more of a responsibility for task and process, on his/her way towards becoming a specialist. However, it has been found that a high degree of mutuality is beneficial for the learning alliance, including a mutual

commitment and active involvement in the learning process. Furthermore, a mutual respect for each other has shown to be of considerable importance for learning (Lewin and Grabbe, 1945).

Scrutiny - The dynamics of the of the Learning alliance
If the Learning Alliances are built up over time, enforced by contracts, agreements and standardized routines, then it is also important to scrutinize these agreements and routines, to ensure they are continuously valid. Any alliance, pact or agreement on standardized procedures is by definition a 'frozen' structure subjected to stagnation or even worse, counterproductive as to the process of creativity and learning. (Leonard-Barton, 1998) Therefore, it is important that standardization processes include processes of "unfreezing" routines and contracts, in order to facilitate the “change “ needed to cope with new demands. The changed routines are then "refrozen" and a new standard is set (Lewin, 1943). Any learning encounter in a relationship structured by a learning alliance should reflect the present situation. Where are we now and where do we go? How do we get there? What are our means and tools? (Greenson 1967) These are questions to be stated and reflected upon by both partners in the relationship. In this way, each step will be scrutinized and reflected-in-action (Schön, 1995) and the alliance redesigned according to the constantly changing situation. The constant scrutiny of how the parties in the relationship are working together, the mutual concerns with the learning alliance, is themselves factors that serve to enhance the learning alliance(Greenson, 1967).

The impact of standardization processes and organizational culture on the Learning Alliance
In order to make sure that strong learning relationships are being developed between apprentices and their supervisors, institutions where they work can develop routines into *what* to consider and *how* to proceed when aiming at establishing a learning alliance (Alänge and Frischer, 1998). By introducing a more standardized way of entering into a good working relationship, these routines can provide a means of limiting variations between different supervisor/apprentice pairs. The organizational culture and the presence of role models can as well influence the establishment of a learning alliance.

III Method - How does Relationship based Supervision work

6. The Research Question

Given our interest in the phenomenon of learning and particularly the role and effect of personal relationships in learning, our aim was to conduct a study to examine the following research question – *How does ‘relationship based supervision’ work as a concept and a method? How does it influence the learning process for both senior as well as junior doctors?* As this main question is quite broad, we broke this question down into number of more concrete sub-questions:

1. What kind of relationships are conducive to learning
2. What are the doctors –both supervisors and supervisees learning
3. How does the organisation context both influence and get influenced by relationship based supervision

7. The Design and Method of the study

In order to answer the above questions the authors designed the study according to action research methodology. All doctors participating in the Relationship Based Supervision Training program from 2001 to 2004 are included in this study. The data used in this study has been derived from various sources of documentation created during the training programs and the supervision sessions. Data includes, the notes taken by the program leaders during the training (i.e.: verbatim comments and reflections from the participants experiences in the training program, as well as the course leaders own observations and reflections), data collected during the supervision sessions (i.e.: participants experiences and responses to various exercises and work in their own supervision sessions), as well as the evaluation forms filled in by the participants at the end of the program.

8. The Sample

The training program in focus was designed and offered to all doctors working in the Halland Region (a region in the southwest side of Sweden). The course was geared specifically to those doctors who were currently supervisors or to those doctors who were interested in becoming a supervisor in their clinic - to either interns or to residents.
Doctors could join the training, if they met the following criteria:

1. They are a specialist or senior doctor who is currently, or will soon have a resident to supervise
2. They are a resident who is currently or will soon have an intern to supervise
3. They are interested and motivated to learning about supervision
4. They have the financial support of the Hallands Regional board
5. They have the support of their Division boss to participate –
    a. They will get paid during their training
    b. They will get the time off from work

To date, the training programs have been conducted annually and 3 programs have been completed. A total of 36 doctors have participated. A brief review of the demographic representation of the course participants is presented in Table 1 below.

Which year?	**Total # Doctors**	**Which specialty?** **Primary care**	**Hospital**	**M/F**
Group 1 (2001)	12	9 (75%)	1 Surgery (1)	6 / 6
Group 2 (2002)	13	8 (62%)	5 Gynecology & Obstetrics (1) Emergency (1), Medicine (1) Pediatrics (2)	7 /6
Group 3 (2003)	11	10 (91%)	1 Surgery (1)	5 / 6
Total	36	27 (75%)	7 (25%)	18 /18

Table 1: The Sample of Doctors Participating in the Training and Study

9. Analysis Strategy

The focus of this paper will be to explore what and how the doctors experienced relationship-based supervision both as a concept and as a way of working. We will examine specifically what they learned and what aspect of the method and process was important to them. We will

use the RELEMO model as a basis for our analysis as it is this concept and method of supervision that we are interested in examining. The analysis will follow the following line of questioning:

a. How defined are the goals and the means to achieve them, in the supervision relations, and if so, what goals and means are set?
b. How 'mutual' is the relationship between the supervisor and supervisee?
c. How transparent and clear is the agreement process (contract) for work?
d. What is the quality of the relationship developed between the supervisor and the supervisee? What levels to the supervisor and the supervisee relate on?
e. How often and how do the doctors reflect and evaluate their relationship and way of working?
f. What is the most important results and learnings achieved for the doctors?
g. To what extent do the doctors try to understand and to influence their working environment (i.e.: clinic) to make it more supportive to supervision?

IV Findings and Discussion

Working in a very systematic and conscious way was a great challenge to all of the participants in the program. The approach followed, supported the doctors to slow down, reflect on their way of working and relating, and then to try to make some changes in their approach, which went against the general cultural grain present in the hospital and primary care world. In this world, it is speed, efficiency and tradition that drives the work and are most valued. However, by the end of the training program, nearly all of the doctors had a chance to experience 'relationship- based supervision in action'. The following represents a summary of the highlights of their experiences.

1. Attitudes and Predisposition

Each of us carries our own perceptions and ideas of what a supervisor could, or should be. It is important to understand our underlying beliefs and attitudes that can steer own our behavior. Hence, during the first day of the training, the participants were asked to identify from their own experience and perception, what their attitude and idea of a good supervisor was, using a critical event analysis method. Although the many of the doctors never received their own supervision when they were training, they were also able to imagine and say what they believed would be a 'good supervision experience'. Their answers included some of the following points: A supervisor is someone that: 'Gives feedback and shares own points of view and values', 'Has time to listen and reserves time for meetings', 'has personal chemistry and is fun to work together with', 'sees what I am doing and can confirm and give me feedback', 'Shares the same goals', ' Is able to share personal experiences with and who cares about me personally', 'Can create a climate that feels secure'. It was from these deep experiences and beliefs that the training program defined its goals and objectives.

2. Goals for supervision

Even if the doctors could identify intuitively what characteristics they wanted to have in a supervisory relation (as defined above), they could not transfer these ideas into a more structured system of goals. For example, when asked what goals were important to set with their supervisees, no doctor could identify, either systematically or specifically, concrete goals. As a result, the participants were presented and helped to co-create during the first session, a structure of goals that can be set, for both their supervision with us as supervisors, as well as goals to set with their own supervisees. The structure of the goals included:

a. *Content goals* - what do they want to learn about, e.g.: technical, professional and medical competences and knowledge. Many of these goals here are defined in formal and specialty standard documents.
b. *Personal goals* – what do they want to learn personally, e.g.: professional identity and personal competences, ethics, balance of work-private life, stress management, etc.
c. *Process goals* - how they want to learn, method competence – e.g.: reading, hands on, watching, reflecting, feedback, experiences, seminars, supervision, etc.
d. *Timing goals* – when they want to learn what – e.g.: time schedule, people involved
e. *Relationship goals* - what kind of relationship do they need or want to have with supervisor/supervisee, relationship competence – e.g.: how mutual, how to divide up responsibility and work, what level to relate; and what kind of relations to develop with other personnel and doctors in the division.
f. *Evaluation goals* - how often should they evaluate the results, relationship and learning experience (content and process), which supports evaluation and feedback competence.

During the training program each doctor also had their own supervisee, and therefore had a chance to try to follow their own systematic process for goal setting and relationship building. The following process was the most common experienced in setting goals:

a. During the first session: the doctors could reflect together with their supervisee on all the possible goals and to explore which were the priorities for their work together and how would they like to work
b. During the second session: The doctor would try to create a process for deciding on which goals to set and to decide on how to reach them (together with their supervisee). For example, what experiences they needed to have, what kind of relationship to have with supervisee, how often to meet, how to and how often to evaluate the learning experience.
c. During third session – the doctors would start to focus on the goals set, evaluate how the learning experience is working or not, what results are achieved, how satisfied they are, what they should work differently or better in the future, etc.

3. 'Mutuality' of the supervisory relationship

One of the goals in the training was to explore the notion of a shared balance of responsibility in the supervisory relationship. While conceptually, all doctors believed that each party in the relationship should be active and responsible in developing the goals, relationship, etc. the practice, they discovered is another thing. Out study found that mutual responsibility whether for setting goals, taking care of the relationship, etc. was in the majority of cases was extremely difficult to achieve. The analysis of the mutuality of the relations between the supervisor and the supervisee found that the doctors divided into three main groups:

'One sided relationship' - The majority of the doctors, tried to take responsibility for setting the focus and goals in the supervisory sessions, while in contract, in nearly all of the cases, the supervisees did not come to the supervision meetings with any clear goals in mind. Mutuality of responsibility in the relationship only came after the first number of sessions, when the supervisor and the supervisee would finally come prepared to the meeting with their own goals and needs clearly defined, and being active in the meeting.

'No relationship' - Some doctors found that their supervisees did not want to be close or clear with them on setting goals and developing an explicit relationship. The supervisees instead avoided contact, tried to be independent and attempted to drive their learning process themselves. In these cases, the doctors felt confused and didn't know how to create contact with their supervisees. Weeks and even months would go by without any contact between the

two. This ‘no relationship’ supervision would of course have implications for both the supervisee and the supervisor later in their relationship, since little would have been documented or evaluated of the competences developed by the supervisee along the way.
‘**Under-dog**’ - Some doctors felt that they had nothing to teach the newly examined doctors, feeling that the new doctors were too advanced technically. This prevented a mutual relationship to get formed, as the senior doctors did not set goals or demand any communication or relationship with the supervisees. .

4. The Quality of the Supervisory Relationships

Mutuality was not the only factor that influenced the relationship between the supervisor and the supervisee. The quality and depth of their relationship (Kantor (1967), Scheinberg and Frischer (2000)) was also an important influencing factor. Each doctor was taught during the first session of the program, that competence development is greatly enhanced when a trusting and personal relationship is created. They were also made aware of how to be more conscious and active in influencing the way or level of relating during supervision. For example, the supervisor and supervisee could choose to be primarily task oriented, personal oriented, ethically oriented, to be simply polite or a combination of the above. The emphasis in the teaching was on the importance of being aware of the depth of the relationship, and the notion that they could influence and suggest a level that was comfortable for them.

In reviewing the experiences when the Doctors were the supervisors, the majority related that they wanted to be as polite as possible, at the beginning of their relations – to the extent that they abdicated their own responsibility in setting goals and in expressing their own wishes, values, needs or demands as a supervisor. The frustration from this ‘non-meeting’ with their supervisees influenced the doctors to be more direct (i.e.: with goal setting) and thoughtful (relationship and process defining) during their next supervisions. In about one third of the doctors, they also consciously tried to find ways to create a deeper, more personal relationship with their supervisees. For example, they shared their own feelings and experiences of being a doctor, about their identity in a particular specialty, mistakes and issues they have experienced, etc. In addition, a number of the doctors invited their supervisees home for a dinner or out for a drink, in order to get to know each other more personally.

When the doctors were supervisees, the majority of attempted to be polite, obedient and careful in the start of the relationship with their supervisor. They presented no goals and reluctantly offered personal information about themselves. The doctors were unaware of their own way of relating and did not seem to feel responsible for defining or changing the nature of the relations. In fact, many of the doctors avoided being clear and explicit in defining their own responsibility in this relation. In nearly all of the cases, the supervisors attempted to share their own feelings, goals and needs in the relationship, and gave feedback on the quality of the contact they experienced with the doctors. Within time, which varied from doctor to doctor, the majority of doctors overcame their polite façade, and developed more task oriented and personal relationships with the supervisors. And in a few cases, a deeper and more passionate relationship developed between the doctor and their supervisor.

5. Reflection, Evaluation and Integration of their learning and style of working?

Supervision meetings often ranged between 1 to 2 hours. While the content and goals of each session could vary, the process for running the supervision meeting was often the same. Each supervision meeting followed a conscious and systematic process for driving the meeting that

used the Gestalt energy or experience cycle as a model (Scheinberg, 1997). Once the supervisor and supervisee checked-in with each other (to say how they were feeling in the moment), they would set the goals for this meeting, determine how to use the time, do the work planned, and then take time to evaluate and reflect on the experience. So, in following this systematic process of working, the doctors had a chance to take up to 5 to 10 minutes to evaluate how the session went – ie: according to the goals and needs set, how we worked, if they felt satisfied, how we should change our process for next time, give each other feedback, decide what has to be done for the next time, etc.
This evaluation process was considered 'holy' by the supervisors. However, it must be noted that keeping time for this reflection step was always a challenge, since most of the doctors had no or very little experience in reflecting and giving feedback, and would have preferred to have skipped this step in the working relation.
The supervisors not only supported the doctors to slow down and to reflect by looking back at what they learned, but also supported the doctors to slow down in order to look forward – to reflect on how they can use and integrate what they learned into their ongoing work and into the next supervision sessions with their own supervisees. At first, many of the doctors complained that we went too slow and had too much time for reflection. However, after a number of sessions, they learned that it is necessary to slow down from the 'running – doing' pace in order to be able to reflect and learn from their experiences.

However, when the doctors were the supervisors, they often skipped this reflection and integration step. Experienced showed that most of the doctors were a bit afraid to take time to evaluate how the relationship and experience was working. However, for those doctors that finally dared to take the time – they found that it was exciting and important to be direct and honest, and not as scary as they imagined it would be. They often got important and useful and appreciative feedback.

6. Key results and learning achieved

At the end of the training program, the doctors were asked to consider the main learning from this training in relationship-based supervision. A number of examples of their experience of learning are documented below, and presented as quotes: '… theory is not the only input for learning – that feelings and reflections are as important'. 'To be able to contribute with feelings and experiences is not so easy'. 'The speed of our work place created an impatience in me that disturbed my ability to slow down and reflect...' That people in the course were so open'. 'To use the Cycle of experience helped me to create a platform for mutuality and learning in my work with my supervisees as well as with my patients'. 'To learn how to listen to the needs of my supervisee and to help them reflect on what they have learned – I only thought that my role was to teach them'; 'At first I thought that the course was too slow and too little theory. It felt boring because I did not understand that I needed to slow down and reflect on how I was doing my work and my experiences'. 'The relationship aspects was totally new and exciting to learn – I need to keep practicing and training'. 'How to set goals with my supervisee and create a living contract'; 'How to agree on the content and process of the supervision and how to establish a relationship in between us'. 'I achieved my goals – to have more insights on how to supervise with a new model and how to give and get feedback'. 'I learned how to see my weaknesses in my supervision and how to improve myself. I learned some tools and models on how to structure supervision'. 'Important to balance theory-practice, listening and activity'. 'Good to have a lot of time to develop relationships and to integrate the learning into my work'. 'Models helped me to become more conscious of how I work and meet others and to create a platform on which me and my supervisees can stand on'.

7. Influence of their working environment

No amount of supervision training can be effective if the role and policies around supervision in the clinics is not clearly defined. As reviewed earlier in this paper, supervision has not been a priority in the health care system in Sweden. Even though the Social board of Health and welfare demands supervision and even though the interns and residents demand supervision for their learning process – little time is set aside for supervision and the competence for being a supervisor is highly underestimated.
Nearly 100% of the doctors who participated in the training program, understood that they needed to work directly with the person who sets the schedule for the weeks – in order to set time aside for supervision on a regular basis. And most of the doctors took the initiative to talk with the leader of their clinic about the value and importance of supervision.

V Conclusions

The Swedish Board for Health and Welfare has concluded that the absence of a structured and systematic supervision of doctors in Sweden has been the main contributor to the poor outcomes of their learning and developmental processes. The Board has thus ruled that competent specialists are to be trained as supervisors to cover the compulsory need to introduce interns and residents efficiently into the profession. In the county of Halland, where this study was conducted, only a fraction of doctor specialists has received supervisor training. And even if almost all the interns and residents has voiced great need for supervision the working climate is focused more on efficiency in production and then on learning. In this context we have introduced a training program/model for supervisors called Relationship based Learning. This model focuses on the relationship between supervisor and trainee in order for them to develop their own structured learning strategies and processes that drives and fit them. However, the Relationship based Learning does not happen spontaneously or naturally. In fact, it requires substantial time and effort, in order to be created and maintained. And, most supervisors are not naturally skilled in creating the conditions needed. In the training it was important to first develop a common understanding, among supervisors, of what a "good learning relationship" could look like. For further understanding, course participants are suggested to practice specific methods and processes to establish a Learning Alliances with their own trainee. This was done over and over under strict supervision of the course leader. Such practices included the introduction of routines and procedures in contracting. Another practice was to influence the working climate in the organization. In fact, many found it necessary to fight for a schedule time that they can sit with their trainee and meet. A common insight among the course participants was that responsibility for the supervision not only lies on the supervisor – but the supervisee also has to take responsibility for his learning. In addition, many supervisors learnt that it became useful to develop a checklist for understanding of the various concrete and possible ways the supervisor /supervisee relationship can develop.

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