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EDITORIAL

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Peer supervision: International problems and prospects

1 | INTRODUCTION

Clinical supervision is the least investigated, discussed and developed aspect of clinical education (Kilminster & Jolly, 2000) despite being essential within initial professional training and mandated by governments. Even the basic concepts lack precision (Martin, Kumar, & Lizarondo, 2017; Milne, 2007; White, 2017). A popular form of supervision is peer supervision, especially peer group supervision (PGS). On the basis of our summary of the available literature, we offer a logical definition of PGS, then adopt an international perspective to consider some worrying weaknesses and working solutions.

2 | COMPARATIVE DEFINITION

Peer group supervision is intended to provide informal, reciprocal, collegial assistance with group members' clinical and professional concerns. Conceptually, this assistance is closest to peer consultation, combined with social support (emotional, informational, and practical help, plus professional companionship). Like supervision (ie, clinical supervision, as defined by Milne, 2007), PGS aims to foster safe and effective practice, though PGS relies heavily on case discussion, with little routine oversight (eg, training programme; employing organization). There is also little overlap in terms of structure, as some PGS is deliberately unstructured, whereas in supervision the supervisor is the clear leader, by virtue of greater experience, expertise and through formal authorization. Unlike supervision, no one in PGS has formal authority over the other group members, and hence no member should logically attempt to monitor, evaluate, direct or assume clinical responsibility for the other group members. This is reflected in the convention in PGS that the leadership role is based on turn-taking. In this sense, PGS is an oxymoron, excluding the main defining feature of supervision, both logically and legally, namely the exercise of formal power (eg monitoring and directing the work of the supervisee) (Saccuzzo, 1997). Peer group supervision places more emphasis on restorative topics, such as professional isolation and burnout. Finally, PGS and supervision differ with respect to their empirical status, as only in supervision do we find a sound evidence-base for supervisor development (Milne & Reiser, 2017).

3 | POPULARITY

Despite the lack of an evidence-base (Borders, 2012) PGS is generally popular, perhaps because it is relatively inexpensive and straightforward to arrange, and as it is collegial, authentic, and non-threatening. For example, a survey of private practice psychologists in the USA indicated that approximately half of the sample were using PGS, or had done so in the past (Lewis, Greenberg, & Hatch, 1988). A similar proportion (41%) was reported in the UK (Townend, Freeston, & Iannetta, 2002) but a smaller proportion (25%) was reported from an Australian sample (Martin, Kumar, Lizarondo, & Tyack, 2016). This is broadly consistent with the review by Borders (2012), who judged that PGS was widely practised. Peer group supervision appears to be most popular amongst those in private practice, those who are more experienced or prefer an adult learning approach, and those working remotely. These findings are consistent with guidance from professional and government bodies, which generally endorse PGS as an acceptable alternative to clinical supervision.

4 | WORRYING WEAKNESSES

In addition to being an illogical concept and an empirically unsupported method, the lack of monitoring in PGS, together with the reliance on discussion, severely limit the opportunities to judge whether clinical practice is safe and effective. This was demonstrated recently by incompetence and fatal misjudgements (Department of Health, 2016). In this sense, PGS neglects to provide staff with proper support and guidance. Similarly, PGS is somewhat fraudulent, implying that supervision is in place when it is not. Consequently, PGS members may jeopardize their professional registration. There is a related 'imposter' aspect, in that the supervisors in PGS are not trained to supervise. Yet, PGS participants risk vicarious clinical liability, as in law this flawed arrangement may be regarded as supervision (Saccuzzo, 1997).

5 | WORKING SOLUTION

Peer group supervision should be properly labelled (eg, "peer consultation"), and supplemented by supervision wherever possible. Peer group supervision should be well-structured, have a trained facilitator, and include a contractual agreement between members. This contract should be explicit about the true nature of PGS (to avoid conveying a medical-legal duty of care). Peer group supervision is not suited to trainees or novice practitioners, those that have moved into a new practice area or context, and those that require extensive oversight of their clinical practice (eg, novel or challenging work). There is a need to re-package and re-design PGS in the short term. Peer group supervision needs proper empirical attention in the long-term.

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