Reflective practice and clinical supervision: an interprofessional perspective

Clouder, D.L. and Sellars, J.

Reflective Practice and Clinical Supervision: an interprofessional perspective

Lynn Clouder BSc MA PhD MCSP, Principal Lecturer, Physiotherapy Subject Group, School of Health and Social Sciences, Coventry University

Julie Sellars MSc MCSP, Senior Lecturer, Physiotherapy Subject Group, School of Health and Social Sciences, Coventry University

Address for Correspondence:

Lynn Clouder
School of Health and Social Sciences
Coventry University
Priory Street
Coventry
CV1 5FB

Tel: 02476 888884
d.l.clouder@coventry.ac.uk

ABSTRACT

Background. In the United Kingdom, the drive to encourage reflective practice through clinical supervision, as a means of ensuring quality of provision in nursing and other health care professions, is now well-embedded, not only in policy but also in practice. However, debate and critique of these concepts is limited.

Aim. The aim of this paper is to draw on research, conducted with undergraduate occupational therapy students and qualified physiotherapists, in order to contribute to the debate about the functions of clinical supervision and reflective practice in nursing and other health care professions.

Discussion. Upholding the notion that clinical supervision has the potential to constitute a form of surveillance, we counter the assumption that it is inevitably confessional in nature. A social constructionist perspective is used to illustrate how clinical supervision might involve a complex interplay of factors that dispel notions of predictability, control and rationality.

Conclusion Despite acknowledging tensions, we argue that clinical supervision is both necessary and beneficial. It can be advantageous to individual practitioners and professional groups in enhancing practice and accountability, and promoting professional development.

Keywords: clinical supervision, reflective practice, continuing professional development, nursing, surveillance, personal agency, resistance

SUMMARY

What is already known about the topic:

- The process of clinical supervision and its benefits in nursing are well described in the literature.
- Clinical supervision enhances learning from practice.
- Clinical supervision can have a positive influence on nursing practice.

What this paper adds:

- A critical debate about the relative merits and potential of clinical supervision
- A challenge to assumptions that people are acted upon rather than individuals with personal agency

INTRODUCTION

This paper offers a pragmatic response to Gilbert's (2001) paper, which adopts a critical stance on the role of reflective practice and clinical supervision in professional practice in the United Kingdom. Our aim is to take up Gilbert's challenge, rooted in his argument that debates about reflective practice and clinical supervision have become sterile, and to enliven discussions by raising issues of resistance and personal agency. Developing Gilbert's perspective of moral regulation (after Foucault 1982) in respect of clinical supervision, we explore conceptions of surveillance and, by using Foucault's (1980) notion of 'the gaze', highlight the ways in which surveillance is ubiquitous; we are all subject to surveillance through social practices at all levels and in all aspects of life. However, one could argue that surveillance becomes more ethical if it is made explicit rather than implicit by developing reflective practice, for instance, through clinical supervision. Acknowledging Gilbert's suggestion that such strategies inevitably increase individual visibility, we argue that he has overlooked the possibility of resistance and the scope for personal agency within systems of surveillance, that create tensions between personal and professional accountability.

THEORETICAL AND EMPIRICAL BASIS OF OUR PERSPECTIVE

We respond to Gilbert's conceptualisation of reflective practice and clinical supervision not in opposition to his thesis but with the intention of developing his ideas further by drawing on both theoretical and empirical evidence. Adopting a social constructionist analysis of social interaction and 'performance' in the workplace, the theoretical work of Goffman (1959/1971) and more contemporary impression management theorists (Schlenker & Weigold 1992; Parker & Kosofsky

Sedgwick 1995) supports the development of insights that extend beyond Foucault's notion of surveillance, a concept that we acknowledge as a 'given'.

Data from two very different pieces of empirical research, the first highlighting the nature of surveillance and the second exploring the scope of reflective practice and clinical supervision, are used to support our perspectives. The first study explored the professional socialisation of undergraduate occupational therapy (OT) students (Clouder 2001). This qualitative longitudinal study was conducted between 1996 and 2000. Involving in-depth interviews, participant observation and documentary analysis, the research revealed the deterministic nature of initial professional socialisation and the part that continual scrutiny by educators, peers and clients played in moulding professional identity. There is every indication that the professional socialisation process continues throughout the career and that, likewise, ongoing scrutiny has a profound influence on how health care professionals carry out their daily work.

The second study, which commenced in 2000, was an exploration of clinical supervision within the physiotherapy profession (Sellars 2001). Data were generated by means of questionnaires and in-depth interviews, conducted across sites within the National Health Service (NHS) in the United Kingdom. Accounts were gained from physiotherapy staff working at different grades, from superintendent to assistant, and from a number of environments including acute, community and mental health settings. The range of participants reflected the breadth of settings in which physiotherapy is provided in the NHS. Findings highlighted the value that physiotherapists placed on having formal 'time out' to reflect on their practice.

However, clinical supervision was found to fulfil a variety of functions at different times, being tailored to meet individual needs.

WORKING WITH CONCEPTUAL AMBIGUITY

Despite little agreement about either concept, we share similar concerns to those expressed by Gilbert (2001, p. 199) with regard to the status of reflective practice and clinical supervision 'exerting hegemony upon nursing and other health care professions'. Such hegemony sprang from the assumption that reflection improves learning and practice (Moon 1999). However, it is evident in the literature that reflective practice has been adopted across a wide range of professions in the absence of thorough knowledge or debate about its underpinning philosophy, or even consensus about its processes, purpose or benefits in terms of learning (Morrison 1995, Clarke et al. 1996, Clouder 2000). Likewise, recent literature on clinical supervision (Burrows 1995, Yegdich 1998, Bishop & Freshwater 2000, Sellars 2001) reveals differences of opinion about rationale and uncertainties about how the process should be operationalised.

Gilbert considers the concepts of reflective practice and clinical supervision in tandem; however, they are not synonymous. Although reflection may be considered integral to the process and purpose of clinical supervision (Bond & Holland 1998, Heath & Freshwater 2000, Lipp 2001), clinical supervision is only one of a number of ways of engaging in reflection. We feel that it is important to make this distinction as it helps to explain the subtleties of the impact of surveillance on practice. The definitions presented below form the basis of our understandings.

> Reflection in the context of learning is a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciation.
> (Boud, Keogh & Walker 1985, p. 19).

The same authors, in describing the mechanism through which reflective thinking occurs, portray an activity in which 'people recapture their experience, think about it, mull it over and evaluate it' (Boud, Keogh & Walker 1985, p.19). This mechanism for reflective thinking suggests a conceptualisation of reflection as a 'monological' process, which is psychological, asocial and comes naturally to most of us.

The interface between reflective practice and clinical supervision becomes evident when considering the numerous definitions of clinical supervision, all of which are underpinned by the belief that it is about learning from practice. Butterworth's (1998, p.12) definition suggests that it is 'an exchange between professionals to enable the development of professional skills'. Wright (1989) expands this definition by focusing on the clinical supervision interaction, suggesting that it is:

> a meeting between two or more people who have a declared interest in examining a piece of work. The work is presented and they will together think about what is happening and why, what was done or said, and how it was handled, could it have been handled better or differently, and if so how?

(Wright 1989, p.172).

In the context of clinical supervision, reflections are externalised becoming, according to social theorist Jurgen Habermas (1972), 'dialogical' in nature. The power and potential of dialogical reflection to develop practice has been recognised (Clouder 2000). However, Habermas was mindful that reflection 'is neither educationally nor politically innocent' (Morrison 1995, p.91). Subsequently, in some disciplines and professions, reflective practice (Bleakley 2000) and clinical supervision (Johns et al. 1998, Johns 2001) have been seen as vehicles for 'confessional' practices, as noted by Gilbert.

During the early 1990s the UK Government clearly saw clinical supervision as a means of ensuring competence to practice and enhancing consumer protection (Department of Health (DoH) 1993). A decade later, it appears that conceptions of clinical supervision have been broadened to place greater emphasis on continuing professional development (CPD) (Butterworth et al. 1998, Burton 2000, Chartered Society of Physiotherapy (CSP) 2000). Whether or not practitioners perceive that benefits emerge from a greater focus on and enforced commitment to CPD, it is clear that reflective practice and clinical supervision have been embedded in and pervade policy documents (DoH 2000, UKCC 1996, CSP 2000) at all levels and, therefore, are unlikely to be displaced in the immediate future.

WHY DO WE NEED CLINICAL SUPERVISION?

Enhanced consumer protection is an ideal to which we all subscribe. The media frequently remind us that health professionals are not beyond culpability. Although

cases such as that of Harold Shipman and the Bristol Royal Infirmary Inquiry (BRI Inquiry 2001) have focused attention on the medical profession as the major culprits in breach of the ethical dimensions of practice (Morris 2002), such cases have a powerful impact on thinking about professional accountability and monitoring across all professions. These cases are extreme. Nevertheless, accountability should range from operating the principle of no harm through to maximising the quality of care offered to patients.

Following a succession of breaches in confidence in professionals working in the NHS in the 1990s, particularly in relation to the actions of Beverley Allitt (DoH 1994), the concept of clinical supervision was galvanised within nursing. In other words, a top-down system that would contribute towards professional regulation and provide a means of ensuring safe and accountable practice was established. According to Gilbert, clinical supervision functions to fulfil these aims in two ways. The first function is to make individual practitioners visible and, through this visibility, subject to modes of surveillance. The second function is to motivate individuals to reveal the truth about themselves, hence the adoption of the analogy of the 'confessional', a metaphor that owes much to Foucault (1980).

Visibility

Notwithstanding arguments to the contrary (Lyth 2000, Johns 2001), we support the notion that reflective practice and clinical supervision can indeed constitute intentional forms of surveillance, a fundamental aspect of social control. Social control is inherent to primary, secondary and tertiary socialisation and is society's means of maintaining the status quo and replicating itself. Tertiary socialisation

(Jarvis 1983), or socialisation into a profession, ensures that professional standards are upheld.

Adopting Jeremy Bentham's principle of 'the panoptican', in which one prison warder in a central tower can control the actions of many individuals because they are never sure that they are not being watched, Foucault (1980) uses the notion of 'the gaze' to explain how the behaviour of the individual is regulated within society:

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze, which each individual under its weight will end up interiorising to the point that he is his [sic] own overseer.
> (Foucault 1980, p. 154-155).

The notion of 'the gaze' might be used to reinforce Gilbert's assertion about disciplining professionals to become self-regulating. The feedback that people gain through being subjected to 'the gaze' provides self-knowledge that they internalise according to societal norms. The process is, as Gilbert suggests, one of colonization and accommodation. However, we argue that, regardless of formalised strategies such as clinical supervision, surveillance is ubiquitous and an inevitable concomitant of the social practices in which professionals engage. For example, professionals discuss patients with colleagues; they perform complex techniques and offer explanations to patients in the presence of colleagues.

Patients weigh the advice that they are given in professional consultation, making silent judgements about the quality of care that they are receiving. Increased access to information through the Internet has enormous potential to impact on patients' expectations, in terms of the most recent treatments and techniques with which professionals 'must' keep up-to-date. In other words, professionals are constantly in the spotlight under which competence is being evaluated. We each, acting as 'warders', scrutinise the actions of others and in turn are scrutinised by others. Sources of 'the gaze' are manifold: our warders are our managers, our colleagues and, not least, our patients. We are under constant surveillance, whether or not we are consciously aware of it or its effects on us, because we are social beings operating within a system of social practices.

Inevitably, surveillance impacts on performance and nowhere is this relationship more apparent than in the experience of student health care professionals (Clouder 2001). Occupational therapy students reported feeling that they were constantly being watched although, recognising the importance of task mastery, they accepted that surveillance enabled vital feedback on performance. Constant scrutiny and 'feeling on show' was often wearing for students although positive feedback, especially when it came from patients, reinforced their developing confidence and commitment. While fieldwork educators were the 'gatekeepers' with the power to deny progress towards entry to the profession, clients' opinions seemed to carry the most weight:

> Getting positive feedback from my patient – that made my day. It depends whose opinions you value but the clients are the only ones who can really tell you if you're any good. They are in the best position to know.
> (Janet)

No one would dispute the need for surveillance of undergraduate students and newcomers to a profession as, at an early stage, an acceptance of being watched is integral to learning within the workplace. However, if professional socialisation is conceptualised as operating on a continuum, one might argue that there is a need for surveillance of even expert practitioners, who continue to learn and adapt, albeit at an advanced level.

Gilbert (2001) points out that surveillance fuels a process of colonization and moulds the professional identity of students and qualified health professionals to produce self-managing individuals, as explained in the later work of Foucault (1986) on the ethics of self. For health care professionals, internalisation of discourses around caring, professional practice and moral respectability shape professional identity in a way that connects 'doing' and 'being' within the social context of the workplace. Hence, the influence of surveillance is intrinsic as well as extrinsic.

Having argued that surveillance is ubiquitous in the social context and visibility is already high, we suggest that surveillance, even when formalised, should not cause great concern. Rights and power that come with professional status also come with attendant responsibilities. Recent evidence (Eraut 1994, Freidson 1994) suggests that professionals have disregarded their responsibilities, especially to their clients, largely

because of a lack of public accountability; this now looks set to change (Laffin 1998). The granting of privileges, in the form of status, autonomy, power and exclusivity, should be repaid through the provision of an ethical and moral service that meets the needs of clients, a principle that is at the heart of clinical governance.

Clinical governance is a policy that reflects the Government's determination to ensure that health service provision is not only transparent but also of high quality. Responsibility for improving the quality of services and safeguarding standards rests jointly on the organisation and on the individual (DoH 1998). One of the key components of clinical governance is the importance of CPD and lifelong learning to ensuring that providers of care have the appropriate skills and competencies. The challenge for all health care professionals is to respond to a rapidly changing health care environment, to question and change outdated ways of working and to explore and utilise common skills in teamwork, while still valuing the unique skills and distinctive qualities of their individual profession (Richardson 1999). The endorsement, in clinical governance policy documents (DoH 1997, 1998), of reflective practice linked to clinical supervision has paved the way for it to be placed firmly on the agenda of all health care professionals.

With increasing demands on individuals to exercise personal and professional accountability and to demonstrate high quality, effective and efficient interventions, the importance of attending to CPD cannot be underestimated. CPD may take many forms but has been criticised for its focus on new knowledge generated externally, for example through attending a course, rather than from 'the reorganisation, distillation and sharing of personal experience' (Eraut 1994, p. 12). However, clinical supervision

provides a practical and economical means of building on experience to ensure quality and optimal standards of care. In terms of surveillance, clinical supervision is a means of formalising 'the gaze' in qualified staff. However, if it is presented as a transparent means of enhancing quality, members of staff who genuinely strive to attain a high quality service clearly embrace it (Sellars, 2001):

> Clinical supervision has been essential to 'sound out' my clinical judgements, it gives you an opportunity to reflect on your practice and compare your ideas with others…so ultimately our patients can benefit. (Respondent 58)

> Being the only physiotherapist in the department clinical supervision has been important for me to be able to discuss issues with a colleague, so I can put theory into practice for the benefit of my patients.
> (Respondent 35)

These respondents seem to perceive that 'surveillance' is not only necessary but also welcome.

More or less truthful and the potential in resistance

Clinical supervision is not inevitably identified with confessional practices (Yegdich 1998). Nevertheless, according to Gilbert, the second function of reflective practice and clinical supervision is to incite individuals to reveal the truth about themselves, hence the adoption of the analogy of the 'confessional' (Foucault 1980). The term 'confessional' implies that the person who is making a confession acknowledges or

admits to some wrongdoing. Its use promotes an extreme, positivistic and rational view of what might occur in a clinical supervision encounter that, in itself, would be off-putting for many practitioners. However, the notion of revealing 'the truth' is taken for granted, which is an assumption that can be challenged from philosophical and empirical perspectives.

The positivistic and rational view of what might occur in a clinical supervision encounter is less easy to predict if we question what is meant by revealing 'truth'. 'Truth' assumes an objective reality (Crotty 1998). However, constructionists argue the possibility of 'many truths', based on the notion that we each experience the world from our own unique perspective, thereby producing local forms of knowledge (Foucault 1980). We argue that clinical supervision encounters cannot be very different to any other experience and, notwithstanding the impact of moral and ethical influences, individuals will seek to preserve the integrity of self on the basis of their own truths. Nevertheless, individuals will learn despite, and not because of, being given the opportunity to 'confess'.

Literature related to both research interviewing and the social construction of 'selves' illustrates the naivety of believing that individuals readily reveal 'the truth' about themselves. There is a growing body of research literature that highlights the negotiated nature of research interviews and the potential for the interviewee to take control of the interview interaction (Scheurich 1997). As in the research interview, the dynamics of the clinical supervision interview are an exercise of power relations, within which the importance of resistance, as an antidote to power, should not be underestimated. The concept of resistance emphasizes that individuals are not simply

acted upon by abstract ‘structures’ but ‘negotiate, struggle and create meaning of their own’ (Weiler 1988, p. 21).

Individuals are actors possessing personal agency to present themselves in the best possible light (Schlenker & Weigold 1992) and to reveal and conceal what they choose in the process of ‘impression management’ inherent to all social interaction (Parker & Kosofsky Sedgwick 1995). Goffman (1959/1971) highlights how individuals put on a ‘front’ that might be more or less truthful. This is illustrated through Scheurich’s (1997) experience of research interviewing:

> Interviewees carve out space of their own…they push against or resist my goals, my intentions, my questions, my meanings. The interviewee may play out a persona just for the satisfaction of the play….may practice stories about herself or himself.
> (Scheurich 1997, p. 71-72).

Scheurich’s insights reveal how staff engaging in clinical supervision may not necessarily adopt a subordinate role in the context of an assumed ‘confession’. Rather it is likely that the supervisee will select, interpret and sanitise issues brought to clinical supervision so that, where subsequent changes to deep-seated beliefs occur, they do so without confession being pivotal. Examples of resistance in a clinical supervision context might include avoidance of addressing certain issues but, more optimistically, could involve being instrumental in tailoring the clinical supervision session to fulfil certain needs. If we move beyond associations with an assumed confession, it is possible to see clinical supervision as something that can provide a

space for exploring conceptions of practice and differences in approach, rather than as an attempt to bring practitioners into line. Furthermore, if locus of control is internal rather than external this may result in improved job satisfaction and retention of staff, positive outcomes already associated with clinical supervision (Butterworth et al 1997). Clinical supervision has the potential to move beyond preserving the status quo to enhancing practice, the full potential of which might be recognised more readily in a group supervision context or in an interprofessional setting.

VIRTUE FROM NECESSITY

There is acknowledgement within the nursing literature of the regulatory function of clinical supervision. Indeed the notion of 'supervision' is an identified source of resistance to clinical supervision within nursing (Faugier & Butterworth 1994, Burrows 1995, Titchen & Binnie 1995). However, as Gilbert suggests, discussion focuses primarily on the process and potential benefits of clinical supervision for clients receiving health care, the professions and practitioners themselves.

The perceived benefits of clinical supervision are strongly evident in the physiotherapy literature (Bishop & Freshwater 2000). Sellars (2001) found that support and enthusiasm for the process was high and there was universal agreement that clinical supervision was a necessary function of professional practice. Physiotherapists saw clinical supervision as an opportunity to reflect on their practice, gain support and advice, and develop both personally and professionally. Having protected time to meet colleagues also made those working in community environments feel less isolated professionally.

Physiotherapists recognised that their units would benefit from their staff having clinical supervision, through improved standards and quality of care delivered to patients. However, there was no indication that individuals felt threatened by the process or saw it as performing a surveillance or regulatory function. This may suggest a degree of naivety or an awareness of scope for personal agency within the supervision process. Perhaps the physiotherapists studied held a positive view of CPD which outweighed the notion of being 'supervised'. These findings support more optimistic views of clinical supervision found in some nursing literature. Butterworth et al (1997), for example, consider that the emphasis of clinical supervision has changed to one of support, professional growth and learning.

Formalised reflection is already embedded in undergraduate physiotherapy and occupational therapy programmes (Cross 1997, Clouder 2000) and, increasingly, students are being introduced to the notion of clinical supervision. However, a study by Richardson (1999) suggests that, once qualified, junior physiotherapists lack the opportunity to use their reflective skills in a formal arena. Developing this insight into practice, Sellars (2001) found that, despite individuals valuing time out to reflect on their practice, heavy workloads, busy schedules and staff shortages often meant that they were unable to take that time. Staff appeared to attend to patients' needs ahead of their own when time was short, an attitude which is typical of the culture in the current NHS, where the emphasis is very much on 'getting the job done' (Eltringham et al. 2000, p. 34). It appears that individuals have been colonised, as Gilbert (2001, p. 203) suggests, into 'selfless obligation'.

If individuals are to acquire the skills and knowledge to practice autonomously, a simple prioritisation in favour of patient care at the exclusion of time to reflect is not a justifiable option. How, if not through encouraging reflective practice, might we promote introspection, analysis, discussion and enhanced understanding of the complexities of practice? Qualified practitioners who have developed expertise operate at such a tacit level that their capacity to analyse their interventions and, perhaps more importantly, discuss their conclusions and teach colleagues might be impeded. Allocation of protected time, set aside within a formalised structure, gives qualified staff space to reflect, and provides them with a framework for their reflections which they can use for their own individual needs. Nevertheless, for such systems to be successful there needs to be a change in culture. Only when individuals start valuing themselves and recognising that the current professional climate necessitates a supervisory process will changes be made. In at least one physiotherapy department such changes seem to have been forced through by the staff themselves:

> My boss doesn't agree with it…but we wouldn't back down on it, the strength of feeling was so high she had to accept people wanted it.
>
> (Laura)

CONCLUSIONS

Clinical supervision in physiotherapy is in its infancy in comparison to nursing, which might explain some differences in perceptions about its purpose. Gilbert's critique of models of clinical supervision in nursing is important, as it politicises a seemingly innocuous process. However, we feel that Gilbert fails to move beyond critique to make alternative suggestions that might address concerns within nursing and, in

addition, CPD needs, issues of professional regulation and quality standards that impact on all practitioners. Within nursing, reflective practice and clinical supervision might still be perceived as being hegemonic but what are the alternative options?

We contend that individuals are always visible and always subject to surveillance as social beings, and that professional practitioners are scrutinised by colleagues and clients whether or not reflective practice and clinical supervision play a part in working life. Practitioners might perceive clinical supervision to be a threatening form of surveillance because it is formalised and has been seen as a top-down initiative. However, we argue that where it is formalised and offers scope for individual agency, it is an ethical form of surveillance. Its potential for individual agency within a context of visibility offers an alternative perspective to those that promote a naïve relationship between reflection and emancipation. Being neither naïve nor partisan, we believe that clinical supervision can be advantageous to individual practitioners and to professional groups in enhancing practice.

We have argued that clinical supervision is both necessary and beneficial and consider that these two aspects are not mutually exclusive if there is less emphasis on a purely regulatory function. However, embedded in our earlier arguments about reflective practice and clinical supervision are tensions between personal and professional accountability that, we recognise, are not easily resolved. As we have illustrated, individual practitioners, personally accountable for the quality of their service, clearly view clinical supervision as a reflective opportunity and a means of addressing CPD needs. Nevertheless, management's responsibility for individual practitioners and service delivery places emphasis on professional regulation. It seems that clinical

supervision is currently employed to fulfil both professional development and professional regulation agendas in some contexts or, at least, that the two agendas have been conflated under the umbrella of clinical supervision.

Our belief is that such agendas cannot coexist or, where there is an attempt to address both, neither will be adequately fulfilled. Practitioners cannot be expected to engage fully with clinical supervision if it is perceived to be ‘a wolf in sheep’s clothing’ as expressed by Gilbert (2001, p.). Earlier, we mentioned the need for transparency in establishing quality health service provision and, in conclusion, we argue that transparency is the key word for the successful implementation of clinical supervision, whatever its intended purpose.

REFERENCES

Bishop V. & Freshwater D. (2000) *Clinical Supervision: Examples and pointers for good practice*. Unpublished Report for University of Leicester Hospitals Education Consortium.

Bleakley A. (2000) Writing With Invisible Ink: Narrative, confessionalism and reflective practice. *Reflective Practice* 1 (1), 11-24.

Bond M. & Holland S. (1998) *Skills of Clinical Supervision for Nurses*. Open University Press, Buckingham.

Boud D., Keogh R. & Walker D. (1985) *Reflection: Turning Experience into Learning*. Kogan Page, London.

Bristol Royal Infirmary Inquiry (2001) *Final Report. Learning from Bristol: the report of the public inquiry into children's heart surgery at Bristol Royal Infirmary 1984-1995.* Command Paper: CM 5207. BRI Inquiry, Bristol.

Burrows S. (1995) Supervision: clinical development or management control? *British Journal of Nursing* 4(15), 879-882.

Burton S. (2000) A critical essay on professional development in dietetics through a process of reflection and clinical supervision. *Journal of Human Nutrition and Dietetics* 5, 317-322.

Butterworth T., Faugier J. & Burnard P. (eds.) (1998) *Clinical Supervision and Mentorship in Nursing.* Stanley Thornes Ltd, Cheltenham.

Butterworth T. (1998) Clinical supervision as an emerging idea in nursing. In *Clinical Supervision and Mentorship in Nursing* (Butterworth T., Faugier J. & Burnard P. eds), Stanley Thornes, Cheltenham, pp 1-18.

Butterworth T., Carson J., White E., Jeacock J., Clements A. & Bishop V. (1997) *Clinical Supervision and Mentorship. It's Good to Talk: an evaluation Study in England and Scotland*. University of Manchester, Manchester.

Chartered Society of Physiotherapy (2000) *Clinical Supervision – Information Paper No. PA45*. Chartered Society of Physiotherapy, London.

Clarke B., James C. & Kelly J. (1996) Reflective Practice- Reviewing the issues and refocusing the debate. *International Journal of Nursing Studies* 33, 171-180.

Clouder D. L. (2000) Reflective Practice in Physiotherapy Education: a critical conversation. *Studies in Higher Education* 25(2), 211-223.

Clouder D. L. (2001*) Becoming Professional: An Exploration of the Social Construction of Identity*. Unpublished Doctoral Thesis, Department of Continuing Education, University of Warwick.

Cross V. (1997) The Professional Development Diary. A case study of one cohort of physiotherapy students. *Physiotherapy* 84(11), 531-540.

Crotty M. (1998) *The Foundations of Social Research*. Sage, London.

Department of Health (1993) *Vision for the future*. Report of the Chief Nursing Officer. HMSO, London.

Department of Health (1994) *The Allitt Enquiry*. Independent Inquiry Relating to Deaths and Inquiries on the Children's Ward at Grantham and Kesteven General Hospital during the Period February to April 1991 (Clothier Report), London.

Department of Health (1997) *The New NHS: Modern, Dependable*. HMSO, London.

Department of Health (1998) *A First Class Service: Quality in the New NHS*. Department of Health, Leeds.

Department of Health (2000) *The NHS Plan. A plan for investment: A plan for reform*. Department of Health, London.

Eltringham D., Gill-Cripps P. & Lawless M. (2000) Challenging values in clinical supervision through reflective conversations. In *Effective Clinical Supervision: The role of reflection* (Ghaye T. & Lillyman S. eds). Quay Books, Wiltshire, pp 19-44.

Eraut M. (1994) *Developing Professional Knowledge and Competence*. Falmer, London.

Faugier J. & Butterworth T. (1994) *Clinical Supervision: A Position Paper*. School of Nursing Studies, University of Manchester, Manchester.

Foucault M. (1980) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. Harvester Wheatsheaf, London.

Foucault M. (1982) Afterword: the subject and power. In *Beyond Structuralism and Hermeneutics* (Dreyfuss H. L. & Robinson P. eds), Harvester Wheatsheaf, London, pp. 206-208.

Foucault M. (1986) The Care of the Self: The History of Sexuality Volume Three. Penguin, Harmondsworth.

Freidson E. (1994) *Professionalism Reborn: Theory, Prophecy and Policy*. Polity, Cambridge.

Gilbert T. (2001) Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing* 36(2), 199-205.

Goffman E. (1959/1971) *The Presentation of Self in Everyday Life*. Penguin, London.

Habermas J. (1972) *Knowledge and Human Interest*. Heinemann London

Heath H. & Freshwater D. (2000) Clinical supervision as an emancipatory process: avoiding inappropriate intent. *Journal of Advanced Nursing* 32 (5), 1298-1306.

Jarvis P. (1983) *Professional Education*. Croom Helm, London.

Johns C. (2001) Depending on the intent and emphasis of the supervisor, clinical supervision can be a different experience. *Journal of Nursing Management* 9, 139-145.

Johns C. & McCormack B. (1998) Unfolding the conditions where the transformative potential of guided reflection (Clinical supervision) might flourish or flounder. In *Transforming Nursing Through Reflective Practice* (Johns C. & Freshwater D. eds), Blackwell Science, Oxford, pp. 62-77.

Laffin M. (1998) The professions in the contemporary public sector. In *Beyond Bureaucracy?: The Professions in the Contemporary Public Sector* (Laffin M. ed.), Aldershot, Ashgate, pp 1-17

Lipp A. (2001) Clinical supervision as part of clinical governance: an instrument of oppression or liberation. *Journal of Clinical Excellence* 2, 203-207.

Lyth G. (2000) Clinical supervision: A Concept Analysis. *Journal of Advanced Nursing* 31, 722-729.

Moon J. A. (1999) *Reflection in Learning & Professional Development.* Kogan Page, London.

Morris J. (2002) Current Issues of Accountability in Physiotherapy and Higher Education: Implications for Physiotherapy Educators. *Physiotherapy* 88(6), 354-363.

Morrison K. (1995) Dewey, Habermas and Reflective Practice. *Curriculum* 16(2), 82-94.

Parker A. & Kosofsky Sedgwick E. (eds.) (1995) *Performativity and Performance*. Routledge, London.

Richardson B. (1999) Professional Development: 2. Professional Knowledge and Situated Learning in the Workplace. *Physiotherapy* 85 (9), 467-474.

Scheurich, J. J. (1997) *Research Method in the Postmodern*. Falmer, London.

Schlenker B. R. & Weigold M. F. (1992) Interpersonal Processes Involving Impression Regulation and Management. *Annual Review of Psychology* 43, 133-168.

Sellars J. (2001) *An Exploration of Clinical Supervision in Physiotherapy*. Unpublished Master's Degree Dissertation, Coventry University.

Titchen A. & Binnie A. (1995) The art of clinical supervision. *Journal of Clinical Nursing* 4, 327-334.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) *Position statement on clinical supervision for nursing and health visiting*. UKCC, London.

Weiler, K. (1988) *Women Teaching for Change: Gender, Class and Power*. New York, Bergin & Garvey.

Wright H. (1989) *Group Work: Perspectives and Practice*. Scutari Press, London.

Yegdich T. (1998) How not to do clinical supervision in nursing. *Journal of Advanced Nursing* 28 (1), 193-202.

ACKNOWLEDGEMENT

Thanks go to Jackie Pritchard and Julian Hargreaves for their constructive comments on a previous draft of this article.