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Running Head: GENETIC COUNSELING SUPERVISOR EVALUATION TOOL

Development of a Genetic Counseling Clinical Supervisor Evaluation Tool

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Abstract

A large portion of genetic counseling education is provided through clinical supervision. This project established a refined list of competencies to be used to evaluate supervisor performance by surveying both students and supervisors. Over 92% of supervisors felt that a student could appropriately evaluate them based on each competency. The competencies were believed to be a fair assessment of supervisor abilities by 95% of students. A standard way of evaluating supervisors will create uniform expectations, serve as a reference of skills/behaviors to strive for and provide a platform for student-to-supervisor feedback.

Key Words: Supervisor, Evaluation, Genetic counseling, Competency, Fieldwork, Student, Rotation

Introduction

The role of the clinical supervisor in genetic counseling is to assist with the professional development of the student while maintaining the quality of care provided to the client (McCarthy Veach, 2009). Training programs rely heavily on supervisors to help students develop the practice-based competencies by integrating acquired knowledge with clinical experiences (ACGC, 2014). Despite being gate-keepers to the profession, supervisors undergo no formal training in clinical supervision nor are they held to a minimal standard of competence, as one does not exist. Approximately 68.4% of clinical genetic counselors (GCs) and 64.6% of non-clinical GC's in North America are involved in teaching and education of GCs and/or GC students, with supervision of genetic counseling students being

one of these roles (NSGC, 2014). In 2003, Lindh et al. created a detailed picture of the genetic counseling supervision landscape by surveying 335 genetic counselors on a broad range of topics, including supervision skill development. Of the 182 respondents who had provided supervision in the previous 5 years, almost all relied on four main methods: trial and error (98.3%), student feedback (96.1%), consult with colleagues (94.4%), and drawing from their own supervision experiences while in training (89.0%). 55% further developed their skills with workshops or seminars.

Informal supervisory skill development may be tied to the profession's lack of formal training and/or practice guidelines (Lindh, 2003; Hendrickson, 2002). This is not unique to genetic counseling; clinical psychologists have also struggled under a similar paradigm (Scott, 2000). In 2004, a set of 34 specific competencies were developed by consensus following a three-day conference. The "Supervision Competency Framework" is delineated by knowledge, skills, values, and social context (Falender, 2004). In 2014, *Guidelines for Clinical Supervision in Health Service Psychology* was approved by the American Psychological Association (APA, 2014). Social work has also recently tackled the issue of supervisor competency by publishing *Best Practice Standards in Social Work Supervision* in 2013. Standards are broken down into the following categories: context in supervision, conduct in supervision, legal and regulatory issues, ethical issues, and technology. (NASW, 2013)

Eubanks Higgins et al. (2013) defined a set of empirically determined competencies for genetic counseling supervisors derived from the literature. A modified Delphi study was performed to refine the competencies and to assess their importance. The study participants were genetic counseling program directors and experienced supervisors. 142 items were rated

and grouped into the following domains: personality traits and characteristics; relationship building and maintenance; student evaluation; student-centered supervision; guidance and monitoring of patient care; and ethical and legal aspects of supervision. This source captures the competencies a genetic counseling supervisor should strive for, and their relative importance to experienced supervisors and educators, however it does not contain any input from supervisees regarding what aspects of the supervisor-supervisee relationship they consider most important. (Eubanks Higgins, 2013).

Student evaluation of their clinical supervisors is required by the Accreditation Council for Genetic Counseling (ACGC, 2014). Upward appraisal offers students an opportunity to evaluate their supervisors as well as provides an opportunity for supervisors to receive feedback about their supervisory roles. Benefits of such appraisal include providing students with a greater sense of ownership and influence during training (Howe, 2010). The purpose of this study is to create a supervisor evaluation tool based on the competencies presented by Eubanks Higgins (2013). A competency-based evaluation tool can help unify the group of supervisors by creating uniform expectations, serve as a reference list of skills and behaviors to strive for in a supervisory role, and give helpful feedback to supervisors who can use the information to grow and improve. Collectively, the evaluations can be used by program administrators to identify global areas for improvement as topics for future supervisor training seminars.

Materials and Methods

Study Design

The refined list of genetic counseling supervisor competencies was developed from the competencies defined by Eubanks Higgins et al. (2013). Study coordinators used the following selection criteria to choose which competencies to include in the evaluation tool: is this competency easily measured, is it an important skill for supervisors to have, and is it appropriate for a student to evaluate their supervisor based on this competency. This refined list of competencies, shown in Table 1, was then introduced to study participants who were asked to evaluate them based of the previously mentioned selection criteria.

Table 1. Refined list of Competencies*.

<p>Orientation</p> <ol style="list-style-type: none"> 1. Conducts an orientation which includes either a verbal or written contract with students regarding the details of the clinical placement and supervisory relationship 2. Describes their supervisory style to students. Delineate supervisor expectations and explain when and how supervision will occur 3. Sets realistic learning goals through discussion with students 4. Makes a plan with the student for progression from observation to participation in genetic counseling sessions
<p>Case-preparation</p> <ol style="list-style-type: none"> 5. Ensures that students have an appropriate amount and type of clinical duties 6. Assists students in obtaining and appropriately reviewing medical records, patient education materials and testing information 7. Assists students in developing a counseling plan and prioritizing goals in the plan for patients 8. Assigns students to patient referrals or roles in sessions that are appropriate to the student's developmental level and experience 9. Facilitates students' understanding of when and how to work with an interpreter for linguistically diverse patients
<p>Co-counseling</p> <ol style="list-style-type: none"> 10. Intervenes during sessions to direct students towards presenting information in a logical, concise and clear manner AS NEEDED to ensure patient care 11. Demonstrates ability to communicate critical reasoning behind clinical practice decisions

12. Elicits students' perceptions of patient psychosocial dynamics
13. Provides guidance to students in effectively documenting clinical encounters

Feedback

14. Strives to provide to students in a timely manner and private area, feedback that is clear, specific, honest, and objective
15. Provides feedback about student behavior rather than personal traits the student cannot change
16. Comments on positive changes made by students in response to feedback
17. Encourages students to develop their own personal styles of genetic counseling
18. Promotes student self-evaluation, self-exploration, and problem solving abilities
19. Helps students process and learn effective coping strategies for emotionally difficult cases

Supervisory approach

20. Creates a positive learning environment through being encouraging, motivating and respectful
21. Advocates for students in the clinical setting
22. Is accessible to students and comfortable in the authority inherent in the supervisory role
23. Maintains appropriate supervisor - student boundaries
24. Models appropriate professional behavior
25. Demonstrates ethical and professional standards of genetic counseling practice (e.g. confidentiality, duty to warn)

* Adapted from Eubanks Higgins (2013).

Participants

There were two target populations for this study: 1) students who were currently matriculating in the Joan H. Marks Graduate Program in Human Genetics at Sarah Lawrence College (SLC) and 2) practicing genetic counselors and geneticists who supervise students from the above mentioned training program. Both students and supervisors were invited via email to participate in an anonymous online survey administered using Survey Monkey. Excluded from the participant pool were students who have not yet completed a clinical genetics rotation, because they would not have the experience of working with a genetic

counseling supervisor in a clinical setting and we believed it was necessary to have such an experience before being able to properly evaluate and provide feedback on a supervisor evaluation tool. The first question of the survey is designed to address the exclusion criteria by asking the year of study and, for first year students, if they have yet completed a clinical rotation. Informed consent was obtained from all individual participants included in the study. This study was approved by the Julia Dykman Andrus Memorial's Institutional Review Board on November 10, 2014.

Data Analysis

The data was analyzed using Microsoft Excel. Values were assigned to ranked/ binary questions. Percent of agreement amongst students and supervisors was calculated for each competency based on each question. Supervisor and student responses were compared to look for trends in the data. Competencies were reviewed for alternation or inclusion/exclusion based on a cutoff of 90% agreement.

Results

Student characteristics

Invitations to the student survey were sent to 44 potential participants, 17 of which were first-year students, 25 second-year students, and two part-time students. Of respondents, 87.5% were second-year students and 12.5% were in their first-year of training. Three first-year students were excluded from participating because they had not yet completed a clinical rotation. In total, 24 students answered questions. One student exited the survey early and only completed questions pertaining to competencies one through nine. 91.7% of respondents

were under the age of 30 (mean age of participants was 27.1 years), 83.3% were female and 79.2% were Caucasian.

Supervisor characteristics

Invitations to the supervisor survey were sent to 100 potential participants, of which 29 people answered questions (29% response rate). Three participants did not answer all questions so there were 26 complete responses. The mean age of participants was 35 years with a standard deviation of 11 years. Over half had been practicing genetic counseling for five years or less with an average years as a genetic counselor of 7.9 years. The same was found for years acting as a supervisor, with the mean number of years supervising being 6 years; over half of the participants had been acting as a supervisor for less than five years. Respondents were all female and 76% were Caucasian.

Participant Responses

Responses to the competencies were overwhelmingly positive. Over 95% of students agreed or strongly agreed that these competencies can fairly assess a supervisor's abilities.

The breakdown of responses is outlined in Table 2.

Table 2. Student responses to whether competencies can fairly assess supervisors' abilities.

	Do you think these competencies can fairly assess a supervisor's abilities?
Strongly agree	36%
Agree	59%
Somewhat agree	0%
Disagree	0%
Strongly Disagree	5%

Students and supervisors were asked if they felt students could evaluate a supervisor based on each competency. Responses are depicted in Figure 1 below. They were also asked

whether they felt that each competency aligned with their expectations of a supervisor (Figure 2).

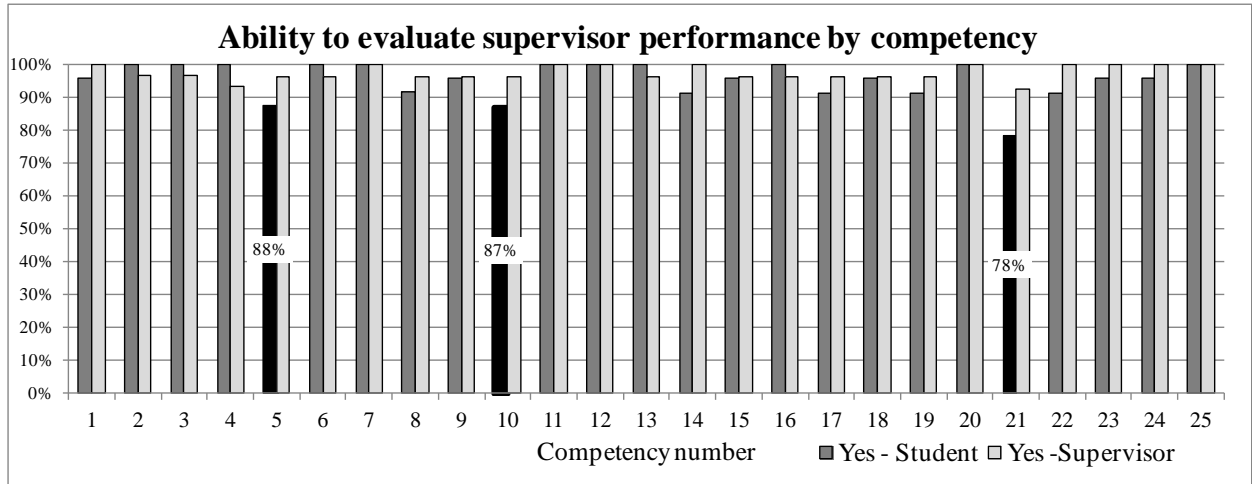


Figure 1. Ability to evaluate supervisor performance by competency: The percentage of students who believed they could adequately evaluate their clinical supervisor on each competency and the percentage of supervisors who believed students could adequately evaluate them on each competency.

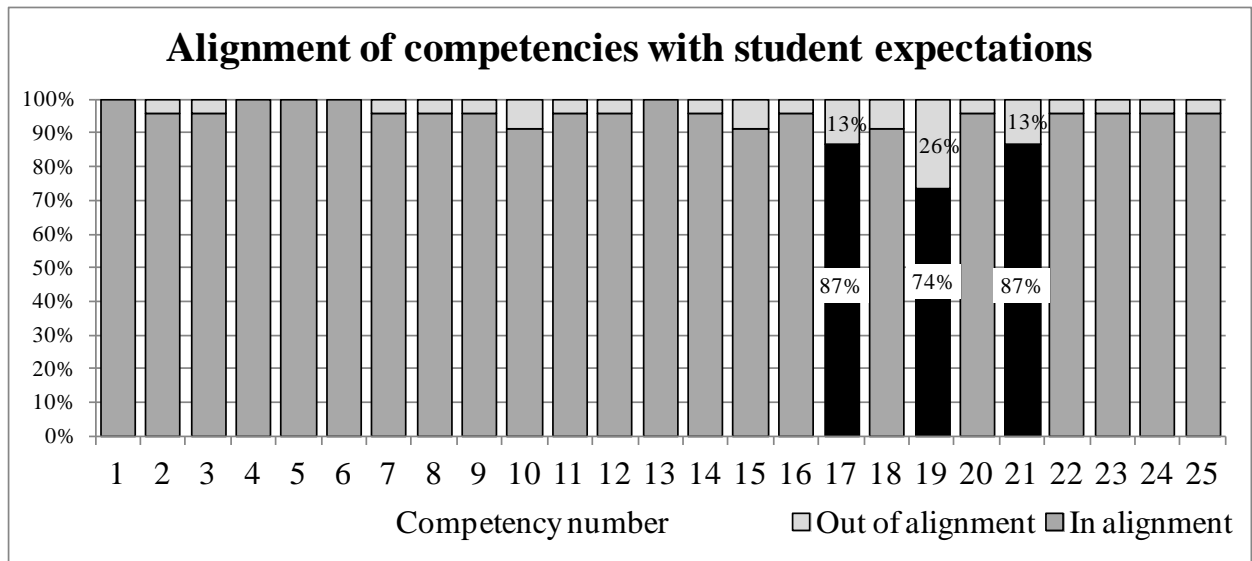


Figure 2. Alignment of competencies with student expectations: The percentage of students who believed each competency aligned or did not align with their expectations of a clinical supervisor.

Supervisors were asked whether they felt comfortable with their ability to perform each competency and whether they felt they could benefit from further training on performing each competency (Figures 3 & 4).

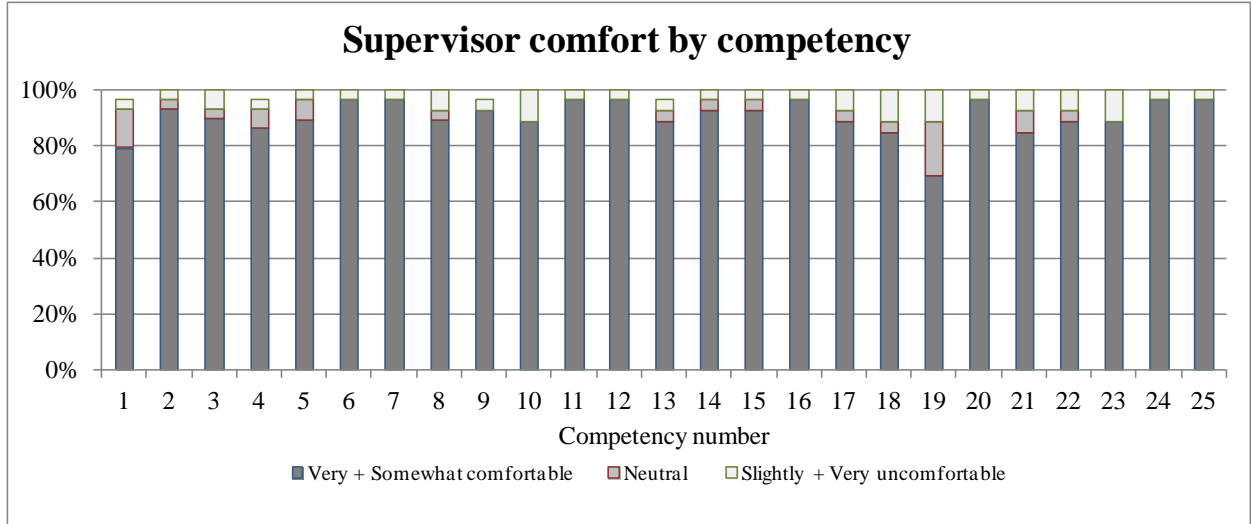


Figure 3. Supervisor comfort by competency: Percentage of supervisors who felt comfortable, neutral or uncomfortable performing each competency.

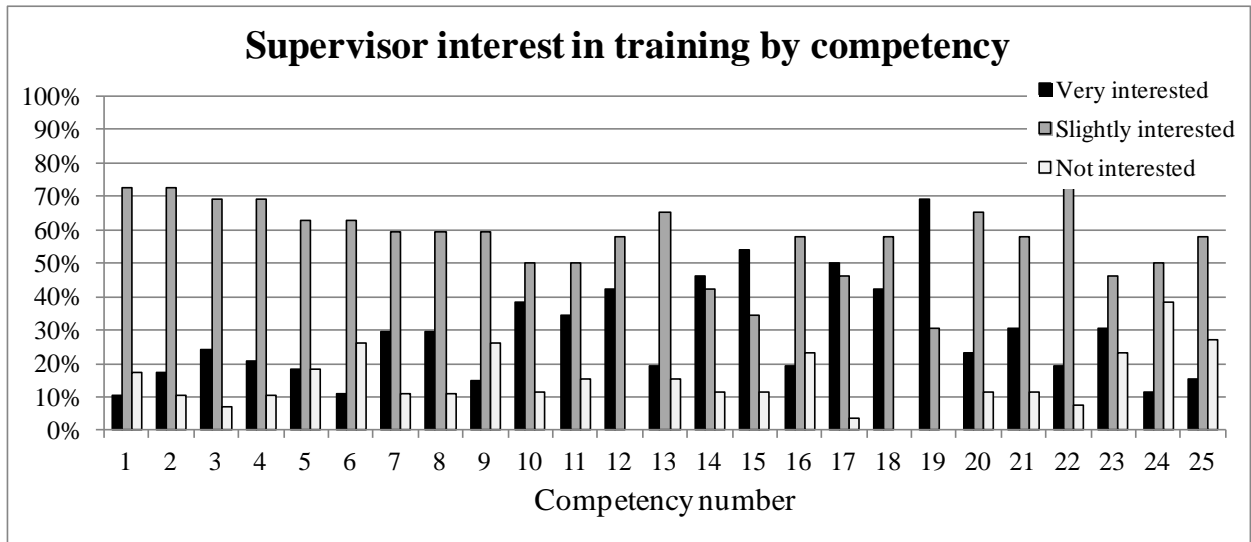


Figure 4. Supervisor interest in training by competency: Percentage of supervisors who were very interested, slightly interested or not interested in receiving training on performing each competency.

Finally, students and supervisors were asked to identify factors they feel should contribute to goal setting (Figure 5). Participants were asked to rate the following factors by level of importance: student’s self-identified areas of weakness, report of feedback from previous supervisors, opportunities available at the particular site, student’s learning priorities, student’s past clinical experiences, and student’s developmental level.

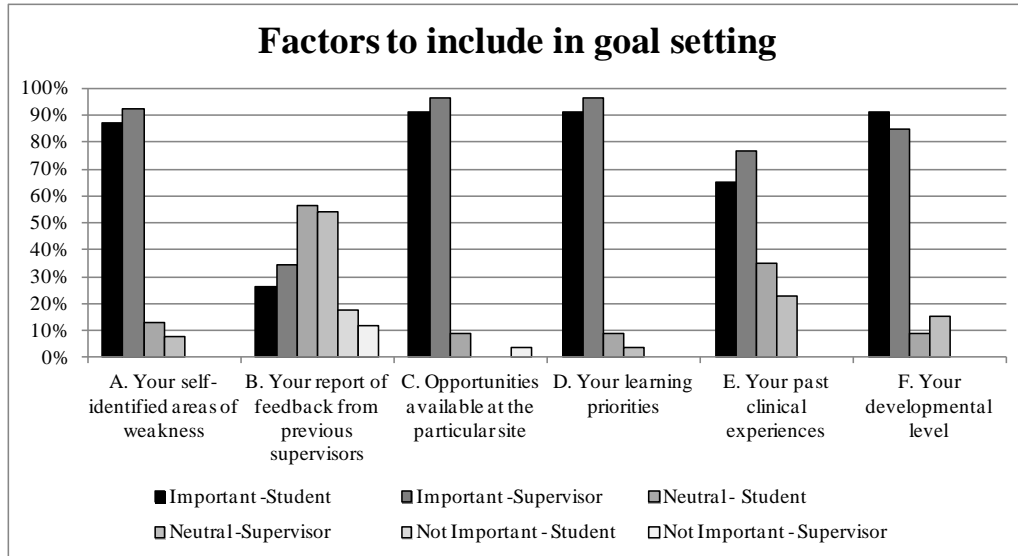


Figure 3. Factors to include in goal setting: Student and supervisor opinions on which factors should be incorporated into a goal setting session at the beginning of a rotation.

Discussion

In order to optimize our refined list of competencies, consideration was given to those competencies that seemed to deviate from the trend of almost complete agreement. There was at least 92% agreement between supervisors that a student could appropriately evaluate them on each competency. This data is not surprising as these competencies were generated by a consensus of highly skilled supervisors (Eubanks Higgins, 2013). In student responses, a natural break was observed at 90% agreement. This statistic coincides with three or more student respondents disagreeing with the suitability of any one competency.

In the section of the survey where students were asked whether they felt they could evaluate a supervisor's performance, responses for competencies 5, 10 and 21 had below 90% agreement. In the section of the survey where students were asked if a particular competency reflected their expectations of a supervisor, responses for competencies 17, 19 and 21 were below the cutoff.

Competency 5 reads, “*Ensures that students have an appropriate amount and type of clinical duties*” (Eubanks Higgins, 2013). The purpose of its inclusion was to assess whether students are being given too heavy or too light of a workload as well as if they are provided the opportunity to participate in a variety of clinical duties. 12% of students versus 96% of supervisors felt that they/ a student could not evaluate a supervisor based on the ability to assign student’s appropriate duties. All of the students felt that the competency aligned with their expectations of a supervisor. Comments from participants were considered to clarify this discrepancy. One student commented that, “*It can be difficult to know what is appropriate. Each rotation is different, and the experience of one may color judgment.*” Another cited the student role in maintaining their workload, stating “*I feel that this is as much the responsibility of the student as supervisor, and therefore cannot be evaluated as readily as other points.*” The issue with this competency seems to lie in the inability of students, especially early in their training, to judge what an appropriate workload is and to separate their role in asking for work from a supervisor’s responsibility to provide work.

Based on the above discussion the addition of a “not applicable” choice on an evaluation tool is recommended. This extra option would preserve the purpose of the question, as well as allow for acknowledgement of a student’s inability to evaluate appropriateness of a supervisor competency in all settings. The collective feedback provided by many students who have a variety of previous experiences will give supervisors an idea of how the student workload at their clinic compares to that of other rotations.

Co-counseling can be a very tremulous experience but, when done well, can ensure patient care while allowing for an increased level of student autonomy (Kadushin, 2002). If done incorrectly, the patient’s focus can shift from the student to the supervisor, undermining

the student's rapport with the patient (Hendrickson, 2002). Competency 10 is designed to encourage supervisors to develop their co-counseling skills and strive towards a cooperative co-counseling dynamic with students. The competency reads, "*Intervenes during sessions to direct students towards presenting information in a logical, concise and clear manner AS NEEDED to ensure patient care*" (Eubanks Higgins, 2013). 87% of students felt that they could evaluate a supervisor and 96% of supervisors felt that a student could evaluate them based on this competency. A supervisor brought up the important point that "*If [a supervisor] ranks low, does this mean they don't intervene at all or that they intervene too much (i.e. more than needed)?*" The addition of a comment box and a prompt to clarify a rating may help distinguish where on the spectrum the supervisor falls. 91% of students felt that this competency aligned with their expectations of a supervisor, so it can be reasoned that this competency is an important component of supervision. On the other hand, student comments also highlighted that "*it is not always needed and could not be applicable in a lot of cases.*" This strengthens the argument for a "not applicable" option on evaluations to be selected if co-counseling was not part of a rotation (i.e. a first-year observation only rotation or a second-year independent session only rotation).

Competency 17 encourages supervisors to allow students freedom to explore their own counseling style while maintaining an appropriate level of patient care. It reads, "*Encourages students to develop their own personal styles of genetic counseling*" (Eubanks Higgins, 2013). Unlike the previous two competencies discussed, this competency was not flagged because students rated it was difficult to evaluate a supervisor on. 91% of students felt they could evaluate and 96% of supervisors felt students could evaluate them based on this competency. This competency was included in the list for further discussion because

13% of students felt that competency 17 did not align with their expectations of a supervisor. Of the students who felt this was outside of the duties of a supervisor, one student commented, *“I have never had a supervisor who did [encourage personal style]”*. In this case, the researchers do not believe that the removal of competency 17 from the evaluation tool is warranted. Helping students to develop their personal counseling style by incorporating acquired knowledge and skills developed through practice is a key element of clinical supervision (Spruill, 2000). This is a potential area for training of both students and novice supervisors.

Emotionally difficult cases can be draining for genetic counselors and establishing effective coping strategies can be very important for personal and professional well-being (Eubanks Higgins, 2009). This concept is included in competency 19, which states that a supervisor *“helps students process and learn effective coping strategies for emotionally difficult cases”* (Eubanks Higgins, 2013). 91% of students felt that they could evaluate a supervisor and 96% of supervisors felt a student could evaluate them based on this skill. Of note, 100% of supervisors were very interested (69%) or slightly interested (31%) in receiving training on this competency. The competency is being reconsidered because 74% of students felt that it didn't align with their expectations of a supervisor. An explanation for the discordance may be that students do not look to their supervisors for emotional support or to learn coping strategies. This is supported by student comments like, *“I feel there's so much that goes on within a typical genetic counseling clinic and that self-care should be something taught outside of the clinic as realistically I don't feel there's time.”* McCarthy Veach & Leroy (2009) dispute this claim by arguing that support and guidance should be the backbone of supervision. When offering support, the supervisor focuses on the students' needs and

when offering guidance the focus is on the needs of the patient. Effective coping and self-care strategies are of vital importance in the helping profession to prevent compassion fatigue and burnout (Peters, 2010). A supervisor's role in encouraging student self-care is a topic that warrants further exploration, so it is recommended for inclusion in an evaluation to tease out the differing opinions of supervisors and students.

Competency 21 states that a competent supervisor "*advocates for students in a clinical setting*" (Eubanks Higgins, 2013). 22% of students felt that they couldn't evaluate a supervisor on this competency citing that "*this advocacy may occur during hours that students are not present.*" 92% of supervisors felt that they could be evaluated by a student on this skill. Only 87% of students felt that this competency aligned with their expectations of a supervisor. Based on feedback from students and supervisors, this competency was removed from the final list because it is difficult to evaluate.

Information was also collected from participants about any other skills they felt should be included in our evaluation. Two independent student participants suggested the inclusion of an additional competency around facilitating introductions to members of the clinical team. One student suggested that the supervisor "*introduce student(s) to as many other medical professionals as possible to facilitate networking, interdisciplinary education and depth of knowledge.*" Another suggested "*Facilitation of introductions/relationship building with other members of the clinic (i.e. secretaries, geneticists, etc.).*" There are no competencies that completely encompass these ideas but two of them combined may be helpful in assessing a supervisor's ability to make introductions. Those are "*clarify roles of genetic counselors at the site in the supervision process*" and "*explain the roles of other professionals (e.g., counselors, psychologist, physicians, and social workers)*" (Eubanks

Higgins, 2013). The combined competency included in the final list reads, “*Perform introductions and clarify role of genetic counselors and other professionals (i.e. psychologist, physicians, and social workers).*”

A significant part of contracting between the supervisor and student at the beginning of a rotation is goal setting (Eubanks Higgins, 2009). There is a section dedicated to it in the Eubanks Higgins, et al. (2013) competencies and this paper explored it further. For all but one of the goal setting factors, over 50% of students and over 50% of supervisors agreed that it was important to include in goal setting. The factor “*report of feedback from previous supervisors*” was rated as not important by 14% of all participants, neutral by 55% and important by 31%. Responses indicated that students and supervisors did not feel it was necessary to disclose feedback from previous supervisors during goal setting for a new rotation. Participants may worry that the disclosure will taint the new rotation with the supervisor and student assuming that the same issues will recur. Participants seemed to be more comfortable with including self-reported areas of weakness, perhaps because it gives students an opportunity to choose which feedback to bring into their new rotation. Previous supervisor feedback was removed from the goal setting competency.

Data collected on supervisors’ desire for training on these competencies did not differentiate any specific competencies as more essential (Figure 4). Supervisors were not asked to rank the competencies in order of their desire for training, thus the results show that most supervisors highly desire training in all of the competencies. A more comprehensive analysis of supervisors’ comfort level with performing these competencies is needed to further clarify appropriate topics for supervisor education. Further research to collect data

about if and how supervisors are using the competencies for professional development as well as a ranking of the competencies in order of comfort level would be helpful.

The primary limitation of this study is a low survey response rate, especially from our supervisor pool (29%). There was almost 100% participation from the second year SLC students and lower representation from the first year class. First year students may have felt as though their limited exposure to clinical supervision had not prepared them to complete this survey. Furthermore, this study represents the opinions of SLC students and genetic counseling supervisors in the New York City area and may not be representative of supervisor-supervisee relationships in other regions.

Conclusion

A standard evaluation tool will help align student and supervisor expectations of the supervisory relationship. This tool will help unify supervisors by creating established expectations and serve as a reference list of skills/ behaviors to strive for. Recommendations for final evaluation forms include a “not applicable” option and comment boxes to help students clarify their ratings. No specific competency had significantly higher levels of supervisor comfort or desire for training. Further research to clarify supervisor comfort with these competencies and how feedback can be used to develop training workshops for supervisors is needed.

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All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

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