Medical Supervision Matters Series

Practical dilemmas and theoretical perspectives for clinical and educational supervisors

Series editors: Della Fish, Linda de Cossart and Tim Wright with clinical illustrations from Dr Jamie Fanning

Booklet 1

Starting with myself as a doctor and a supervisor

Della Fish

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Please note that the ideas contained in this publication are my own and are not necessarily shared by any of the institutions for which, or within which, I work.

I have been privileged that this booklet is the first of five that make up ED4MEDPRAC's Supervision Matters Series, and I hope that the resources and ideas it offers will be of use for, and provide support to, all those involved in the complex and important process of clinical and educational supervision. Since this booklet is not really designed to stand alone, I hope it will encourage readers to access the series as a whole.

Della Fish
July 2015

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Overview of contents across the series

with the Academy of Medical Educators' (AoME) domains

Booklet One Unit A
Starting with myself as a doctor and a supervisor (AoME domains 1, 2 and 6)

Introductory matters

A1. What *as a person* do I bring to my supervision of doctors?

A2. What is required of me as a clinician who supervises doctors?

A3. How do I see virtues, values, character education and professionalism?

A4. How do I construe the nature of clinical practice and why does it matter?

A5. How do I view the nature and status of medical knowledge?

A6. How do I see patients and the relative priorities of patient care and supervision?

A7. Review: How do I now see supervision?

Booklet Two Unit B
Practical dilemmas about supervision and teaching (AoME domains 2 and 3)

B1. How does and how should clinical and educational supervision work in practice for doctors?

B2. What is teaching, what is education and how would I characterize 'good teaching'?

B3. How, in the moral mode of practice, should I engage in teaching my supervisee?

B4. What do I see as the basis of my authority and my agency as a supervisor?

B5. How can I cultivate character, virtue and moral reasoning in my supervisee?

B6. What is education theory and what do I need to know about it as a supervisor?

B7. What do I need to understand about the role of language in supervision?

B8. How should I prepare, as a teacher, and what is involved in the appreciation of my practice?

Booklet Three Unit C
Practical dilemmas about the learner and learning (AoME domains 3, 4 and 5)

B9. A reflective account of what I have learnt from being observed while teaching.

C1. What is involved in negotiation by the Educational Supervisor of the learning agreement?

C2. How can that agreement be turned by the Clinical Supervisor into a practical curriculum for the learner?

C3 How can I study my learner and what do I know about the nature of learning?

C4. How can learning something practical be turned from training into education?

C5. How can clinical thinking be learnt?

C6. How should I understand and promote the progress and continuity of each learner?

C7. How, as a supervisor, should I now best plan for my supervisee's learning and my teaching?

Booklet Four D
Practical dilemmas about assessment and evaluation and final appendices

(AoME domains 5 and 6)

D1. What does 'getting the measure of a learner' mean, and how should I do it?

D2. How can I use formal and informal assessment to educate my supervisee?

D3. How might character, virtues and moral reasoning be assessed?

D4. What is educational evaluation and how can I best design and use it?

D5. What have I learnt from being observed as I teach, by an expert in pedagogy?

D6. Preparing and presenting my portfolio.

Appendix 1: Creating an extended piece of level 7 writing for Appraisal or a University
Appendix 2: Fish 2012, Chapter 11: 'Enriched Informal Assessment: diagnosing where learners are, enabling more focussed teaching'.

Resource Booklet
Theoretical perspectives on educational practice

Theories of teaching and learning: a commentary on foundational 'academic' theories used to inform the practice of education

1. Aims and intentions
2. The role of theory in educational practice
3. Language in Education
4. Philosophy
5. Psychology
6. Sociology
7. Conclusion

Afterword: a note on Adult Education

Reflection for Doctors as a means to learning and for theorizing medical and educational practice

Introduction
Reflection as used in professional practice generally
Reflection for doctors

Each booklet contains its own reference list

Booklet One

Contents

Introductory Matters

Introductory Matters

The aims of these booklets

The aims of these booklets are to enable readers to:

(i) gain a sound understanding of educational values and principles, developed through critical consideration of reading, writing and other set activities

(ii) recognize the problematic and complex nature of educational practice and develop ways of arguing for, and defending confidently, personal solutions to the dilemmas inherent in supervising practising doctors

(iii) know about, and how to draw appropriately upon, educational theory by weighing up the pros and cons of educational thinking in relation to the practical dilemmas of sound supervision, so as to provide worthwhile learning experiences for supervisees

(iv) grasp clearly the significance of sound education for the on-going safe and humane care of patients

(v) ***have an informed and clear understanding of what the new GMC's standards mean in terms of the evidence that each supervisor must provide to gain GMC approval and thus continue this work, but with greater enjoyment.***

The educational intentions of the booklets

The educational intentions of the booklets are to help supervisors of practising doctors to:

(i) explore critically what is involved in ensuring safe and effective patient care through good supervision, and consider:

- the nature of supervision for postgraduate doctors and how it relates to 'good' teaching, 'sound education' and 'virtuous conduct'
- working in 'the moral mode of practice' to produce humane, knowledgeable and safe practitioners, (AoME area 1);

(ii) analyse critically what is involved for supervisors in acknowledging a teacher's moral responsibility to nurture learners, as well as to consider critically:

- some key ways to 'study' the learner and
- how to draw on some simple educational principles about learning, to establish and maintain a sound environment for facilitating learning (AoME areas 2 and 3);

(iii) think critically about basic educational principles related to:

- seeing the importance of preparing and planning for teaching that facilitates learning
- setting educationally worthwhile intentions for the learner
- ensuring that learning is enhanced through assessment and the monitoring of educational progress (formal or informal)
- using the assessment of teaching as a practice and the evaluation of teaching to promote the continuous improvement of practice and the nurturing of learners (AoME areas 3, 4 & 5);

(iv) understand how to support and monitor continuity and progression and guide learners' personal and professional development (AoME areas 5 and 6);

(v) make wise decisions about what is involved in how to evidence continuing professional development as an educator (AoME area 6).

See Appendix C of GMC (2012) and AoME (2010 a and b) for how the AoME areas relate to GMC requirements.

The possible uses of these booklets

The contents of all booklets are pitched at the equivalent of Level 7 (university postgraduate study at Certificate and Diploma level). In all cases these booklets must be read in conjunction with the readings cited at each stage and the completion within these booklets of the notes required. In addition, for those seeking evidence for formal recognition of their work (as in (i) (ii) and (iii) below), a completed portfolio must be kept of all the formal writing required within the study booklets and clear evidence of

the completion of all the formal writing activities within these booklets must also be available. Given these conditions, the 5 booklets that make up Supervision Matters can be used as:

(i) the study guide for a validated university module, the complete contents providing a basis for gaining 20 credits on a pathway to a postgraduate certificate/ diploma in medical education, through a successfully completed set assignment that charts (evidences) the module member's educational development throughout the module by reference to the writing produced during the module.

(ii) the study guide to an ED4MEDPRAC taught module which, provided there is full evidence that the taught elements have been fully attended and all the work required completed appropriately, can later provide evidence for engaging in a university's Approval of Prior Learning (APEL) process, and facilitate membership of AoME.

[Note: This process can only be operated by a university that already offers other related medical education modules at level 7. In addition to the above conditions, this usually requires the successful completion of a written assignment set by that university (normally 5,000 words), thus generating 20 credits which would count as one complete module towards their Certificate / Diploma pathway in Medical Education.]

(iii) a way to fulfil the educational component required for **Level 2 GMC recognition and approval as a named Supervisor** (required to be in place by 2017 for all who act as a key supervisor for practising doctors)

(iv) a way of providing important understanding of the nature of educational practice and its relationship to theory for anyone teaching in a healthcare practice context.

In all cases we would advise following the units of study carefully ***in chronological order,*** because these resources are designed on the basis of a spiral curriculum (returning to issues and deepening them as it proceeds), see below, p. 26. Booklet 1 offers an important Introductory section containing advice about study at this level together with Unit A; while Booklets 2 - 4 develop and extend understanding of the practice of medical supervision through Units B to D; and the Resources Booklet provides further details needed.

We believe that the various practical dilemmas highlighted in these booklets as inherent in the supervision of practising doctors can and should be discussed, debated and explored further wherever possible with experts in medical education.

The editors' philosophy: education is a professional practice in its own right

The crucial differences between these resources for teaching doctors and others that might appear to be like them, but which are 'simpler' – indeed, even 'simplistic' - are to be found in our philosophy, as offered below.

(i) We respect the ***practice of education*** as a complex and problematic enterprise – seeing it as like the practice of medicine itself. So we do not try to simplify it and to set it out as tips for teachers. We believe that the practice of education can no more be fairly represented by a few simplified and apparently easy tips than can the practice of medicine.

(ii) Thus, we see teaching as a ***professional practice*** that requires an understanding of ***educational principles and values*** - not simply as served by learning a list of skills. The principles of education direct a teacher's practice - just as the principles of medicine direct a doctor's.

(iii) We construe ***education as a moral and professional practice***, which serves learners, who are as vulnerable as patients for whom we have moral responsibility. This, we believe, requires a virtuous disposition and a proper professional relationship between teacher and learner.

(iv) We respect the intellect of the doctors we are addressing (you the reader), seeing you as a professional who will actually enjoy — better than trying to pretend teaching is simple — the truth that ***being a good educator requires being challenged by complex problems and the need to bring well-honed criticality to the educational needs of each particular and individualistic learner.***

(v) We recognize that teachers – like doctors – frequently face serious practical and moral dilemmas that demand ***sound decision-making and wise professional judgement,*** and that these spring from an understanding of the principles of education (as well as medicine), which have to be harnessed in the heat of the action of practice – and exercised fast and frequently. Thus, educational thinking (decision-making and professional judgement) lies at the heart of the professional expertise of teachers and needs to be developed in the educators of doctors.

(vi) We see as the problem for the teacher or supervisor of practising doctors, that much that supervisees need to learn ***cannot be taught by simply telling them or using Power point extensively.***

(vii) We therefore believe that a one-day course on all you need to know about teaching (like a 'quick-fix course' on medicine) would seriously short-change its members and distort the nature of the practice. So ***we do not here offer some simple communication skills and techniques in an apparently objective and context-free list, to be learnt parrot-fashion and then 'applied' unthinkingly to practice.***

(viii) We understand that the education for becoming a serious teacher of practising doctors (which postgraduate doctors and their patients deserve) not only takes more than a couple of days but also that its results will not occur overnight in sudden startling changes to practice. Rather we see this as a lifelong journey, which once started upon will continue endlessly to fascinate and challenge.

Thus we see education as a professional practice, which is complex because, it rests on a virtuous disposition and a thought-through values base.

We believe that the practical questions facing supervisors of practising doctors will not have simplistic answers but rather that they are dilemmas needing to be solved by each supervisor according to their own character, values, educational understanding and sound philosophy.

These booklets therefore seek to enrich the educational understanding as well as the technical practice of supervisors, and to help them see teaching as an inescapably moral enterprise.

Our concern is to enrich practice. To this end our text contains at various points practical contributions from Jamie Fanning, illustrating the practical outcomes of his in-depth understanding of these educational matters as a doctor in current practice who supervises his juniors.

Write in the box below what you hope to gain from these booklets.

Note-making box

From old to new medical education: important contextual issues

We believe that the General Medical Council (GMC) is moving the medical profession beyond Modernising Medical Careers (MMC) towards a more modern approach to the education of practising doctors. We see as part of this the new arrangements for the Recognition and Approval of the Clinical and Educational Supervisors throughout secondary care, which will come in line with those for General Practitioners, (GMC 2012). In response to this we want, right from the start, to situate the contents of this booklet clearly at the cutting edge of ***New* Medical Education**. As an educational enterprise, it will start with your current practice and introduce into it **new ways of thinking *and of being***, that will enable you to challenge the status quo of what we call 'old medical education' (which sees teaching as 'telling', assessment as simple measurement, and which is based on 'tips for teachers').

We believe that the content of this booklet can bring you *new educational understandings,* that will help you develop — and where appropriate change — the ways in which you work with your learners. We believe that this will be a better and more powerful educational basis for gaining your supervisory recognition and approval.

In the first two chapters of *Developing the Wise Doctor* (Fish and de Cossart, 2007), we expressed our conviction that much is amiss with old medical education. This includes:

- the basic **un-thought-through assumptions about the *simplistic* nature of teaching, learning and assessment**, on which educational and clinical supervisors have conducted training in clinical practice (for example, some Training the Trainers courses), and on which current medical curricula are largely built

- the **inappropriate language that characterizes old medicine** (referring

to postgraduate doctors as 'trainers' and 'trainees', and to patient care as coming in 'packages' or 'diseases')

• the **ill-judged criteria (or simply lack of them) for success and failure** in medical practice AND in medical education

• how we **neither recognize nor address *educationally* our learners' failures** — and fail to show appreciation of high success

• the **inadequacy of the dominant ideas and mindset** that drives both teaching and assessment in the clinical setting (which includes presenting healthcare as a commodity and the need to measure everything. Here: 'action is valued only for its outcomes and where the high ratio of these outcomes to necessary inputs' is what measures success; and where practice is 'dependent minimally on the good judgement of independent practitioners'). (See Dunne and Hogan, eds. 2004, p. xi).

The language we habitually and sometimes casually use conveys how we see things and often comes to shape (and even distort) our very attitudes to ideas.

You don't 'make widgets' in a hospital, so patients are not 'things' but people. Patients, as people, are not there simply to have 'packages of care delivered' to them. Doctors do not simply follow protocols and work 'on the shop floor'. These are images from trade and industry. Doctors are members of a profession, not factory workers. They treat vulnerable human beings, not 'diseased bits'! Medicine is a profession NOT a trade! We should resist its 'industrialization' and 'commodification'.

In the light of all this, we seek in all booklets to work with you to disclose and develop the power of a very different and more adequate set of educational ideas and language, that will enable you to provide education and assessment for postgraduate doctors that will, in its turn, improve the level of patient care (which of course is at the very centre of all our work). Teaching doctors – and to an extent other health professionals – in the clinical setting, is seen as fraught with the following problems. (See next page.)

But this too is changing. The newly proposed 'Framework for Generic Professional Capabilities' was published as this Booklet went to press. The consultation paper (GMC, July 2015) proposes a model that places 'Professional values and behaviours' at the centre of its framework (GMC, 2015:11). It also highlights the significance of 'personal characteristics' (GMC, 2015:11). It also, encouragingly, suggests that 'the professional judgement of a trained expert assessor could form part of the overall assessment of those complex, generic, professional capabilities'.

Contact time with teachers has been reduced recently.
(This is seen as negative BUT it can be educationally useful.)

The quality of learning needs to be raised, but reduced time for work and lack of educational thinking in healthcare suggests this is impossible.
(But it isn't).

All medical / healthcare teachers need better and more up-to-date educational understanding.
(Yes BUT, this is about understanding and using sound educational principles and values, not developing more teaching skills which are mostly common sense.)

Teaching in the clinical setting needs to be seen more broadly and can be done more effectively.
(It should be mainly done WITHIN clinical practice, and extended outside it.)

Teaching needs to be raised above the level of training, but few know what quality teaching — as a practice — actually involves.
(Better quality does NOT mean just doing more of the same.)

Assessment of doctors in the clinical setting has been narrowly and poorly conceived and as a result has become a bore, a drudge and at worst a cynical tick-box exercise.
(The current curricula see assessment as separate from teaching and learning. This is educationally UNSOUND! There are better ways.)

As the blue writing in the box above shows, there are starting points here for a better way forward. Write your initial thoughts about what we are saying about medical education in bullet points in the box below.

Note-making box

How to read education books, chapters and articles

NOTE: The following three sections of this Introduction provide a guide and help for reading and writing in the educational domain, and clarify what we mean by 'criticality'. You may need to re-read these before turning to the second part of this booklet, and you should expect to come back to them as you work through the booklets.

Be clear about why you are reading something or have been asked to read it. This enables you to focus on the relevant parts of a text and to use appropriate reading strategies.

You are likely to be reading for some of the following purposes:

- to gain background information
- to help you or challenge you to weigh the pros and cons of an argument
- to identify the structure of a particular author's argument
- to understand a concept or set of concepts better
- to find alternative views to challenge an argument.

This is very different from why you might read in medicine, which is probably mainly about gathering specific facts, and being guided about what to do in practice.

Once you have identified your purpose(s), you will know what you can and can't skip.

Always ask yourself:

- what kind of an article is this?
- or what other chapters does this book contain?
- who is intended to read it?
- what else do I know about it, or about the author?

Remember: the author has a purpose too.

Try to discern the main purpose of the text / piece of writing. What sort of a text / writing is it (article or chapter)?

Try to get a handle on the author and their place in the literature of the topic.

The art of reading in our context is to know when to skip judiciously. [Not in this booklet!]

Active readers are selective readers. Very rarely will you need to read a whole book from cover to cover in order to prepare for a discussion etc. Mostly you will be asked to look at shorter items. But some of them will have an eye on secondary school teachers as a key audience and you may need to ignore issues that are only for them and adapt educational principles and ideas to your own context in Medical Education.

Effective readers are ACTIVE readers. As they read they:

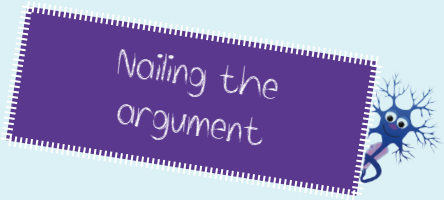
- know what they are looking for and how to find it
- relate new knowledge to old knowledge
- make patterns and connections
- ask questions about the text.

Being an ACTIVE reader means being a CRITICAL reader.

Being critical in this context does not mean criticising for the sake of being argumentative. It means understanding how ideas have been arrived at, and evaluating their strengths and weaknesses.

Some of the main features of critical reading are as follows:

- **recognizing** the writer's purpose
- **recognizing** the KIND of text this is (and what are appropriate responses to it)
- **recognizing** the writer's assumptions and underlying values (social, cultural and historical influences)
- **recognizing** patterns of argument
- **linking ideas in the text to other ideas (including your own) and to other texts**
- **understanding how language choices reflect values and indicate power relations.** For example, is the language that of a psychologist? A feminist? Is the writer intimidating the reader by using obscure words or jargon? Is the writer persuading with emotive words and phrases, such as 'statistics show', 'democracy means', 'surely no-one would disagree that...'
- **recognizing how the text positions the reader** which is about how the reader is being addressed — is this as if the reader is a colleague with a theoretical interest or a practising professional? Does the writer want the reader to agree or does the writer invite debate?
- **exploring alternatives to the stated idea**
- **recognizing the assumptions and underlying values that YOU** bring to your reading.



Understanding the text's structure and the argument being deployed is vital in intelligent reading of books, chapters in books or articles.

Do not use *anyone's* writing just as a superficial mine for attractive quotations which you then — at *your peril* — remove from the context of the overall argument and use for your own ends!

Whole books have a continuing argument (unless they are just thrown together). And, of course, individual chapters within a book also offer an argument, but do not always contribute very clearly to the overall thrust of the book. The arguments of books or a chapter can be quickly retrieved as follows.

- Consult the **table of contents** which may help you to decide whether or not a book will be of use to you. BUT, it doesn't always give enough information to decide.

- **Look at the introductory chapter (most academic books have one)** which showcases the main ideas and arguments discussed later.

- Similarly, the **final chapter** often gives you a good overview of the contents, and points you in further directions.

- The **index list and reference list** show you the main ideas and authors quoted in the text, thus allowing you to find relevant information without having to read all the text. This also shows you what has ***not*** been taken account of by the writer (or where s/he has drawn **the parameters of the territory addressed**).

In articles (or even in marking an essay!) you can ask the following.

- What does the title tell you? What does it lead you to expect?
- Who is the author and what do you know about them?
- When was the article written and how does it fit/relate to its territory?
- What are the writer's credentials, affiliations, prejudices, values (are they even acknowledged?)
- What IS the subject (issue, question), does it correspond to the title? How?
- What is the writer's thesis? Is it acknowledged? Is it educationally worthwhile?
- What main points are made (what is not said)? Is the argument persuasive / referenced / evidenced? Are terms and meanings clear?
- What is the writer's attitude to the material? Are the counter-arguments considered?
- What evidence is offered (and of what sort)? Are assumptions recognized / challenged?
- What sources are cited and what kind of sources are they?
- What does the reference list tell you?
- What is the bottom line? Does the conclusion follow from the key steps of the argument? Is it justified? What confidence in it do YOU have and why?
- Is it readable and are the arguments convincing even if you do not agree with them?

Using this and some of the strategies listed on previous pages you should be able to deduce the writer's purpose, the kind of reader / audience imagined by the writer, and you should try to **draw a diagram of the argument**. Then think about what you would now ask the author.

It is unlikely that you will be able to write a simple list of points, as there will be examples, side issues, and an acknowledgement of counter arguments.

You should be able to place the article you are exploring in the wider context of knowing, thinking, understanding.

Starting to read: developing a discipline

Always expect to read educational texts several times.

- Start by making a note in your diary of the author; date; title; publisher.

- *SCAN through the reading to get an overall feel for its* ***structure***, and try to deduce the **writer's intention;** where s/he is coming from; who it has been written for, and why. (Look for the clues.)

- *Look carefully at the* ***title*** *and the first paragraph*, which *should* tell you something about what to expect. **It should alert you to the argument being presented.**

- *Think about what YOU want to get out of it.* Frame some relevant questions.

- *Be prepared to 'translate' examples from, say 'school learning' to postgraduate learning* (the PRINCIPLES will still apply); but skip anything that is clearly irrelevant to you.

- *Read the text through carefully, for the first time*, trying to get a grip on the logic of the argument and IGNORING anything you find difficult to follow.

- Read it through a second (and if necessary a third) time, trying to fit in the bits you didn't understand before, **getting a full grasp of what is being said, and thinking critically about it.**

As you do so: (unless it's a library book) use a highlighter to mark a few sentences that:

- are eye-catching and summarize an interesting idea that is new/useful to you

- you would want to discuss with others

- are worth quoting because they say something you see as important and offer it in better words than you could create.

Then in bullet points, try to summarize the main points in the argument presented.

And try to find out something about the writer and the context of the writing (use the internet & library).

Warning: a dictionary is a layman's tool.

If you use a dictionary when reading, remember that it is a layman's tool, and is no more appropriate to aid understanding in depth the specialist use of educational words than it is for understanding, say, a doctor's specialist use of medical terms. **The assumption that it is possible, always, to give one, simple, clear, exact and accurate definition of a word, is a snare and a delusion!** In education, just as in healthcare or medicine, you have to develop gradually a feel for the fuller meanings, implications and associations of words used by specialists.

How to write for educational purposes

If you are following a taught module, you should expect to send your Formal Writing Activities in electronic form, ahead of the relevant taught session, as directed in the study guide associated with that module. Always bring to class TWO printed-out 'hard' copies of all Formal Writing Activities, to work on and share.

If you are a reader who is working in any other group than a taught module, you will need to think about how to share your ideas with others and how to ensure that in your peer discussions you are really enhancing and refining your ideas. You may need an experienced educator to chair this.

The activity of writing

The activity of writing is a process that extends our learning. It is not, contrary to popular belief, merely something one does to demonstrate what one has already learnt. The writing activities you are asked to engage in as part of these booklets are there to help you think further, and as such are a very important part of the whole process.

The following offers further advice.

Most writing you do will be personal not scientific. You are asked to use the personal pronoun "I", to share with us your own thinking and being, and to write openly and honestly about your understanding of supervision, educational ideas and your practice.

Some of the very early Formal Writing tasks will ask you to capture, in note form where you are at the very start of the course. You are asked here to respond to the writing task set in your own words with your own ideas — and to write in sentences and paragraphs. Sometimes you will be asked to list ideas in bullet points, in which case you do not have to write sentences. This writing will give you a base-line of what you thought and did before you came to grips with what the course offers you. Write in Word please, preferably using Arial or Calabri at 12pt and single spaced. Use a new document for each unit.

Unless you are asked for bullet points, please always write in sentences. Short sentences are always safer if you are not very confident about prose writing. Then put all the sentences about the same thing in a paragraph (or several paragraphs if your argument is continuous), and give a sub-heading to the set of paragraphs that are all about one topic.

This is about having in your mind as you write, the reader and his/her needs to find their way through your writing. They need BRIEF help about how your work is structured at the start of any writing that is more than half a page long, and they need signposts (in the form of sub-headings) as they find their way through it.

All writing should have some sort of overall logical order (should be going somewhere, with a clear sense of direction).

NB: Attend carefully to what has been set in each writing task, and ask yourself what is being required of you. Each task has been very carefully phrased to ensure that you focus on and use your time on something that is useful and central to the development of your understanding.

Sometimes you are asked to write in empty boxes within this booklet, in which case there is no need to capture this on computer.

The importance of criticality and what we mean by it

The supervision of practising doctors is a postgraduate enterprise. Postgraduate education is a university level enterprise in which criticality is the defining characteristic. It means meeting ideas and processes, opinions and what are claimed to be 'facts' with a weighing up of their veracity, appropriateness and logic.

At this level of education and at this level of clinical practice, patients, colleagues, your supervisees as learners, and your own teachers all have the right to expect that you will be engaging critically with every idea and process in your practice.

Criticality flows from but also generates insight. In essence it is a fresh intelligent appraisal or weighing up of some aspect of theory and/or practice.

What is its central focus? It can be found in a variety of activities.

Readers at postgraduate level are expected to critique (think about, or appreciate, the pros and cons of what they are asked to read), bringing a mixture of 'literary criticism' and initial scepticism to the ideas offered. (See above.)

Here, too, the ideas of one writer can be used to help critique the ideas of another. In any writing you do, and especially in your main assignment, this is important. This requires much more than listing lots of references and referring broadly to one key idea associated with each name — or worse, just compiling a long list to impress the reader. A thorough and insightful critique of a smaller but highly relevant cadre of literature might well be academically more worthy — depending on the context and purpose of the critique.

The ideas of writers and the body of theory that is generally recognized as 'education theory' can be used to critique practice. This is much more than saying that a new idea / theory / insight / model from theory should inevitably be immediately applied to practice, as something practitioners inevitably should be doing!

Rather than use the word 'apply' we would talk about theory 'enlightening' practice. Think about the difference in meaning here.

Practice can also be used to critique theory! This might mean rejecting the simplistic ideas implicit in the word 'apply' that is so often assumed to be what practitioners should do with theory! It might mean on the other hand that the ideas of theorists (who after all are typically separate from practice and do not know of the practical and particular context in which practitioners work) are not appropriate to foist directly onto practice. If you think this is so in a given case then you need to explain why.

Practitioners can critique their own or another's practice, through new insights into practice — gained by their own insightful and creative thinking about their practice. Such new insights may or may not have originated from reading theory!

Importantly too, practitioners can theorize their own or another's practice by investigating an aspect of it in detail, recording this and then turning what is found into useful principles to guide practice. By then seeking insights into these results, through exploring any other related theorizing — either as found in the practice of others or as written up in books and articles — they can link their more private theorizing to wider theory. This is known as practitioner research.

Plagiarism and the reference list

Warning 

Please note carefully that using the published ideas, as well as the words, of others without due acknowledgement of their source is the highest crime in all professional and academic worlds. It is, after all dishonest and amounts to the purloining of someone's property. In work for universities (where a careful electronic check is often made of writing that is submitted in assignments) it would bring instant failure of that assignment, and sometimes worse!

Doctors, of course, would be reportable to the GMC were they to be using other people's words as if they were their own (ie, without full acknowledgement).

That is why you have been advised to make careful note of the full reference for anything you read and use the proper referencing process in your written text and in a properly constructed Reference List at the end of your writing.

The way this booklet has been set out offers one model of how to do this. Look carefully at how other authors' work is referenced in the text — and how the page number is included — and at the reference list at the end of each booklet, and how this is set out.

Brief overview of Units A to D

Underlying all that we offer in Booklets 1 to 4 is the unquestioned acceptance that all supervisors of postgraduate doctors must attend to teaching them the necessary and appropriate medical knowledge and skills that they need for their work, along with the processes and procedures that underlie and support safe patient care.

We assume that supervisors, by the very nature of their seniority and role, do not need to be taught about this content by us, the authors (even if we could). What we seek rather, is to help you, as reader, consider the pedagogical choices available for such teaching and also to think deeply about other more tacit matters that seriously affect the quality of patient care, how you see patients, and how you might enable supervisees to learn about them and thus become wise doctors.

Overall these four main Units focus on helping you to think like a teacher. Each Unit focuses on one of an overall set of dilemmas. These are:

(i) dilemmas about the personal and professional identity of the clinician /supervisor
(ii) dilemmas arising from the nature and practice of teaching / supervision
(iii) dilemmas arising from the nature of learning and the individual learner
(iv) dilemmas about the role, values and practices of assessment and evaluation.

In each Unit there are a number of sections, each of which explores a key question that has to be faced by anyone seeking to take their teaching responsibilities seriously, and provide a quality service to their learner. Indeed, it is true to say that every teacher makes decisions about each of these questions. This they do either tacitly (without ever giving tongue to them but nevertheless acting in ways that show their views about them), or, more professionally, they make explicit that they know what they are about in teaching and can articulate what they stand for as educators.

In order to prompt some serious thinking about these four overall dilemmas, the reader is engaged in interactive note-making activities as well as engaging in thinking, and set reading and writing activities.

Permeating themes

Throughout these booklets there are also recurring permeating themes that offer new perspectives across the dilemmas raised. These permeating themes are:

(i) the general idea that teaching is 'a practice' in its own right (like medicine)
(ii) our view that attending to the moral mode of professional practice (clinical and educational) is more desirable than merely providing for the development of the professional as technician
(iii) the allied idea that in developing professionals there is a duty to attend to more than the factual knowledge and skills required (known as the **epistemological** aspects of the professional's job), but that it is just as important to nurture and develop the person the practitioner is, (known as the **ontological** matters) which are also significant
(iv) the general belief that rigorous reflection on practice is the best way of learning from what happens in the practice setting
(v) our particular principle that in attending to the development of any professional at any stage, the following five aspects are essential for the educator to attend to: being; knowing; doing; thinking; becoming.

Key point

Knowing as a doctor is about all the knowledge (more than textbook) that you bring to your work.

Being a doctor is about the whole person you are that you inevitably bring in entirety to your work.

Thinking as a doctor is about your decision-making and judgements in respect of patients.

Doing as a doctor is about the skills you engage in and abilities you harness in the service of patients.

Becoming a doctor is something you continue to learn throughout your professional life.

Whenever you see this sign it should alert you to note that ideas about one of these themes is being extended further

Permeating themes that cross all those items in the list below

Teaching as a practice in its own right	The moral mode of practice, virtues and values	Epistemology and ontology	The importance of reflection	The importance of being; knowing; doing; thinking; and becoming

UNIT A: Starting with myself as a clinician and a supervisor

A1. What *as a person* do I bring to my supervision of doctors?
A2. What is required of me as a clinician who supervises doctors?
A3. How do I see virtues, values, character education and professionalism?
A4. How do I construe the nature of clinical practice and why does it matter?
A5. How do I view the nature and status of medical knowledge?
A6. How do I see patients and the relative priorities of patient care and supervision?
A7. Review: How do I now see supervision?

UNIT B: Practical dilemmas about supervision and teaching

B1. How does and how should clinical and educational supervision work in practice for doctors?
B2. What is teaching and how would I characterize 'good teaching'?
B3. How, in the moral mode of practice, should I engage in teaching my supervisee?
B4. What do I see as the basis of my authority and my agency as a supervisor?
B5. How can I cultivate character, virtue and moral reasoning in my supervisee?
B6. What is education theory and what do I need to know about it as a supervisor?
B7. What do I need to understand about the role of language in supervision?
B8. How should I prepare, as a teacher, and what is involved in the appreciation of my practice?

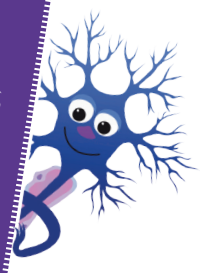
UNIT C: Practical dilemmas about the learner and learning

B9. A reflective account of what I have learnt from being observed while teaching.
C1. What is involved in negotiation by the educational supervisor of the learning agreement ?
C2. How can that agreement be turned by the clinical supervisor into a practical curriculum for the learner?
C3 How can I study my learner and what do I know about the nature of learning?
C4. How can learning something practical be turned from training into education?
C5. How can clinical thinking be learnt?
C6. How should I understand and promote the progress and continuity of each learner?
C7. How, as a supervisor, should I now best plan for my supervisee's learning and my teaching?

UNIT D: Practical dilemmas about assessment and evaluation and final appendix

D1. What does 'getting the measure of a learner' mean, and how should I do it?
D2. How can I use formal and informal assessment to educate my supervisee?
D3. How might character, virtues and moral reasoning be assessed?
D4. What is educational evaluation and how can I best design and use it?
D5. What have I learnt from being observed as I teach, by an expert in pedagogy?
D6. Preparing and presenting my portfolio.
Appendix 1: Creating an extended piece of level 7 writing for Appraisal or APEL
Appendix 2: Informal Assessment: Fish 2012, Chapter 11

Expect to take approx. 7 hours to complete Unit A. You should allocate 3.5 hours to sections A1 to A3.3, and 3.5 hours to sections A3.4 to A7.



Unit A

Starting with myself as a doctor and a supervisor

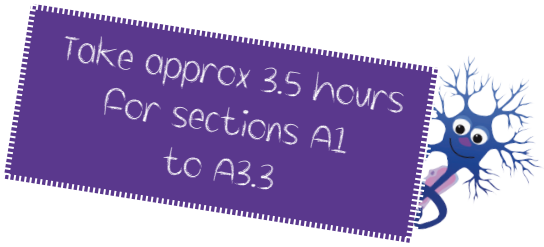
AoME areas 1,2 and 6

All that follows will challenge and disturb some of your ideas and practices and support and confirm others.

If this is not the case, it will have failed educationally!

Unit A: Starting with myself as a doctor and a supervisor

AoME areas 1, 2 and 6



Unit A:
Introduction

This whole Unit is focused on Ontology (which is about the nature of being — in this case, 'being a doctor'). It is, therefore, about you as the person that you bring to your supervisory responsibilities. As a doctor you are dedicated to looking after each patient whom you may meet as a human being or serve in a supportive capacity without actually meeting them. But you have little time to think about yourself and are rarely the focus of professional nurturing and support. This unit encourages you to explore who you are as a person, your virtues, values, beliefs and assumptions about medical practice.

The seven sections in this Unit focus on what we believe are the important starting points in making the supervision of doctors a more professional and effective process. They will form a basis for all that follows, and help you to record your personal base-line against which you can chart your development in understanding and practice through this booklet.

We believe that much of the quality of supervisory practice depends on what the supervisor ***as a person*** brings to their work. We also think that how a supervisor sees both clinical and educational practice is at least as important as their educational skills and clinical knowledge. Indeed, in our experience, supervisees who value their supervisors highly, often cite these matters as significant.

In Unit A, as in all other Units, you will be learning a new language (***look carefully at the definitions***) and new ways of thinking. You will be seeing ideas anew and changing how you understand some of them. That enriched understanding will equip you with a wider basis from which to make your own educational choices as a wise teacher. You should be prepared to begin to recognize the crucial differences between words that seem very similar but may even have opposite implications for an educator. Try to get a handle on these quickly. Also be patient in following the arguments set out for you, and be ready, once you have gained a full understanding of them, to think critically about them. We shall try to help you with this.

Remember to complete the work in the order it is presented.

Note: If you are following a taught module organized by ED4MEDPRAC Ltd you should work from page 27-45 inclusive to prepare for your first half day face-to-face seminar, reserving pages 46-79 as preparation for your second session.

Section A1:
What as a person do I bring to my supervision of doctors?

A1.1 Introduction

This section is focused entirely upon helping you to clarify your personal and professional identity as a doctor and an educator, by which we mean it will help you to articulate what you stand for and what you bring to your professional and supervisory work. It is what might be seen as your personal signature. As we have already indicated, this is the foundation of teaching. Who we are is where our teaching 'comes from', whether we know it or not.

Exploring one's professional identity begins by asking questions about our existing practices and situations. It means taking a 'sceptical stance towards what we have always seen as "self evident" assumptions, recognizing our tacit ways of knowing and being, and challenging those policies, practices and procedures we have previously espoused uncritically'. (See Trede and McEwen, 2012: 33; and Bauman, 2004.)

In all this, we shall assume for the moment that supervision is indeed a highly significant form of education and is offered by supervisors who teach individuals and groups of doctors in training (supervisees). Later we will explore this assumption in more detail.

A1.2 The intentions of this section

This section seeks to enable you to:

- think quite deeply about the person that you bring to the supervision of those doctors for whom you have formal responsibility
- consider how important this dimension of teaching is in relation to being a good supervisor
- introduce yourself as a person, as well as a supervisor.

A1.3 Who am I?

As the starting point (which in teaching should always be to get to know the learner), please begin by providing some important details about yourself, as follows. You might even consider offering a sheet of this kind about yourself, to each new supervisee when you first meet them.

Writing activity A.1: Introducing myself Set up a computer document for Unit A

At the top, type the Writing Activity code (A.1) and title, (as above) and set up a running footer with your name and the page number. Please date every entry.

Set down in continuous prose, interspersed with bullet points where appropriate, the key basic details about yourself. Write no more than three or four paragraphs and answer the following questions. Remember never to name names other than your own! Remember to use the personal pronoun "I".

Now please attend to the following:

Where do you work? (Describe, do not name, your specific workplace, role and key activities.)

Provide a simple list of the clinical settings in which you teach.

List by post (eg: FY1; FY2; Core; Reg1) **all your current supervisees and say whether you are their clinical or educational supervisor.**

What, in your experience, characterizes doctors *as teachers*?

Describe what, for you, is involved in the process of teaching, in your normal clinical settings. (Try to answer this question at greater length than the others).

Give a brief flavour of who you are as a person (likes, dislikes, interests)**.**

Save this document as: Unit A, your name, your cohort. eg: UnitAFredSmithcohort4.doc.

There will be more to add to this writing at the end of this section.

A1.4 What is the importance of the person that I bring to my supervision?

In your work as a doctor/clinician, you are often expected to keep something of a distance from your patient and to appear 'objective' whilst being approachable. It is possible to be an efficient physician / surgeon without sharing very much of yourself with those you treat. It is not the same in education. Indeed, as Hansen reminds us:

> to judge from its long tradition, the most important factor in the practice of teaching is the person who occupies the role of the teacher. No other factor has greater weight in influencing the intellectual and moral quality of the....[education that] children and adults receive...(Hansen, 2001: 20)

It is, of course, a moot point as to whether this is not also true for medical practice, but whether this is so or not, it is certainly the case for those practising education.

So, you may be surprised that the focus of this first Unit is about you as a person, rather than about the skills and strategies you use as a supervisor, but as you will see from Hansen's comments above this is not a new approach to becoming an educator. He reminds us that 'ever since teaching first emerged as a practice', the following questions have been seen as important:

Who should fill the role of the teacher?
What kind of persons should they be?
What should they do in relation to their learner?
What should they know?
How much autonomy or freedom of action should they be granted?
Who should prepare them for their work, and how?
Who should evaluate them and how?

These questions are perennially 'vexing', and 'personally overwhelming for anyone who is thoughtful about them' (Hansen's words p. 20). This is not only because as medical educators we are crucially obliged for the sake of individual doctors and the future of the profession to consider such queries in depth, but also because there is no simple, clear, unequivocal and universally agreed answer to them. But there are some generally accepted educational values and principles that guide the way we might respond to them. **We now shall try to consider the first two questions above.**

So: Welcome to a world in which your **character, virtues and values,** (your own priorities as shaped through your beliefs and experience of life) form the basis of action and thought, and where making a sound educational argument (based on generally agreed educational principles) is the only touchstone for ensuring that you are doing your best in the service of your learner and, therefore your patients!

This is almost certainly a different world from the one you inhabit daily as a clinician serving vulnerable patients, where theoretical knowledge (like anatomy, for example) at least appears to be 'certain', absolute and universally agreed, and where research has (for the moment at least) laid down specifics about what to do in practice (even though such research has to be tailored to the individual patient).

Note-making box

What values and priorities do you bring to working with a patient?

How would you describe yourself when working with patients?

How would you describe yourself when working with supervisees?

What do you actually bring to both?

Hansen, (2001:21) makes the point that a key aspect of an educator's work is to 'be mindful of the person one is, and of the **conduct** one enacts in the presence of learners'. He argues, powerfully, that: 'Such mindfulness goes hand-in-hand with developing a **moral sensibility**, by which I mean a **disposition** of mind and feeling centred round attentiveness to students and their learning'.

Here we are already meeting some important words and concepts which will become central to thinking about what is involved in supervision. The following box offers their definitions.

1. Conduct
Conduct comprises the characteristic unity, pattern and continuity (even integrity) in the doings of a person. Conduct reveals or expresses in action our character (our thoughts, beliefs, ideas, aims and intentions). Character is substantially revealed by how we regard and treat others. Personality is something we are born with, character we continue to develop throughout our lives.

In sharp contrast to behaviour, conduct is unique to that person. This is about 'personhood' and 'agency'. Personhood here means the person you are — which is cultivated throughout life. Your agency as a person is about having the disposition and capacity to engage in chosen actions, rather than to act as a robot or as the enactor of someone else's intentions.

It is one's conduct that so influences learners, influences their attitude to learning with that teacher, influences who they become as a person, and leads to considerable 'indirect learning' (learning from the way the teacher conducts themself).

People can improve and enrich their conduct throughout a lifetime.

2. Behaviour
Behaviour concerns itself only with the visible. We can be made to behave by others (while they are present at least). This means that our behaviour cannot be guaranteed to reflect our personal ideas, thoughts, beliefs and character, and may not be found consistently in our activities, but may have a haphazard and also thoughtless quality about it. Hansen suggests that it can be mechanistic.

A trainer's role might be to inculcate behaviour, but, a teacher's is to develop conduct, character, and a recognition of the difference between this and mere 'behaviour'.

3. The moral sensibility of the teacher
This brings a person and their conduct together under one unifying way of seeing and doing things that sheds light on the kind of person they are and reveals their philosophy as a teacher.

4. Disposition of mind
This is about a particular leaning or inclination, which in a professional teacher is often about how they see and are attentive to a learner — any learner who works with them — as a person, how they sense what they should be teaching them, and how best to do so. This is akin to how a doctor 'senses' how best to care for their patients.

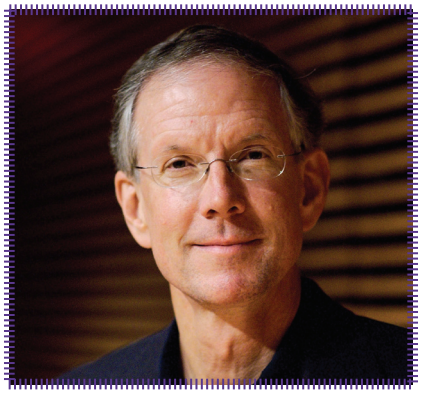
5. Character and personality
Character is arguably about having a principled disposition towards embodying certain specific traits. Such qualities of character colour what we are, do and think. Virtuous traits can be developed by us and our teachers throughout our life. By comparison, personality, (the sum of the kind of person we are overall) is endemic in our genes and is not, under normal circumstances, something a teacher can or should seek to alter. (See Carr, D: 2003; 2007). The absolute distinction between these two however is not absolute, as we shall see.

Think about these words and the concepts to which they refer (the idea(s) that lie behind them). In your supervisory practice, for example, do you talk with your supervisees about how they conduct themselves and can you think of examples of how they behave, which illustrate the differences?

A1.5 What is David Hansen's full argument here?

You should now try to read Hansen, (2001: 28 - 40), which makes these points and more. Try to get a grasp of the argument being presented, and notice how the key words are being used. Make any private notes you need to or highlight the text if it belongs to you.

If you have any trouble accessing any of the readings listed as required in any of the booklets, please email us at fish@ed4medprac.co.uk or decossart@ed4medprac.co.uk and we will provide a private link which may help you.



David T. Hansen is The Weinberg Professor in Historical and Philosophical Foundations of Education at Columbia University's Teachers College. His interests are in the philosophy and practice of teaching, and teacher education and the moral and ethical dimensions of education, as well as the nature of values and inquiry, and related themes. He is a Past-President of the John Dewey Society and of the Philosophy of Education Society.

His 2001 book, *Exploring the Moral Heart of Teaching: towards a teacher's creed*, published in New York and London by Teachers College Press, offers an excellent illustration of what teaching as a moral practice actually means.

Our comments so far

It is possible, of course, to argue that teaching is an impersonal activity and needs none of this kind of thinking and awareness. Indeed, many of the books about medical education currently available treat teaching in postgraduate medical practice as a matter of 'training in technical and non-technical skills, attitudes and practices', plus a bit of theory. (See, for example, McKimm and Swanwick: 2010); some offer 'strategies, tools and aids' (see, for example, Dent and Harden, 2009). They attempt to simplify education, and provide practical guides to what they call 'teaching made easy'.

Our view, as writers and teachers, is that this amounts to a dangerous and distorting succumbing to the demand for a quick-fix approach to supervision and medical education generally. We see it as providing simple and protocol solutions to how to teach, which ignore the values base of education as a practice and undervalue the importance of sound educational principles. Indeed, we fear it might well ultimately deprive medicine of practitioners who can exercise the same discretion and professional judgement about education as they do about their clinical practice. If this happens, as we see it, patients as well as the profession will be short-changed and teaching and supervision will continue to be seen as boring, simplistic and unchallenging.

A1.6 Your agency

All this makes agency an important issue. Indeed, we would argue that exploring one's work as a supervisor is about scrutinizing one's journey in the development of one's agency as an educator. For example, every decision a supervisor makes about intervention with a supervisee will either be driven and shaped by some outside agent's intentions and requirements, or by our own individual personal/professional concerns as supervisor — or, more likely — by a mixture of both. Outside agents

include the supervisee's curriculum, the requirements of the GMC, the Royal Colleges, the Deanery, and all the specifics of hospital policy and financial constraints. Our own agency as supervisors, by contrast, relates to decisions we make in response to the local context of everyday practice. These are driven by our clinical and educational values and principles. A crucial example is the way we decide how to prioritize our time, and how we balance clinical and supervisory duties. These are difficult matters for which supervisors need help and guidance from a clearly developed educational philosophy. This booklet is designed to enable you to build yours.

The figure on the following page offers a view of that journey. Look at it and think about what it means, and its implications for you. We would suggest that your journey as guided by this booklet will be from the green lowlands, through an examination of what we have called 'edu-action' (see below for definition) and on to the start of the mountain proper (number one in the blue writing above). Reaching the beginning of Education (in the blue words) is the basic goal for becoming a recognized supervisor. But, of course, the diagram also offers an enticement to you to aspire to climb further up the mountain through other courses and a lifetime of experience!

The mountain of educational practice (Fish, 2012:39)

(Read this figure from the bottom upwards)

EDUCATION

Engaging in *praxis* as a life-long journey (claiming own agency)

↑

3. Towards educational *praxis*

Being an educator engaging in the practice of education

↑

2. Understanding the nature of education and self as a person and an educator

Being a teacher engaging in the practice of teaching

↑

1. Thinking like a teacher (beginning to be own agent)

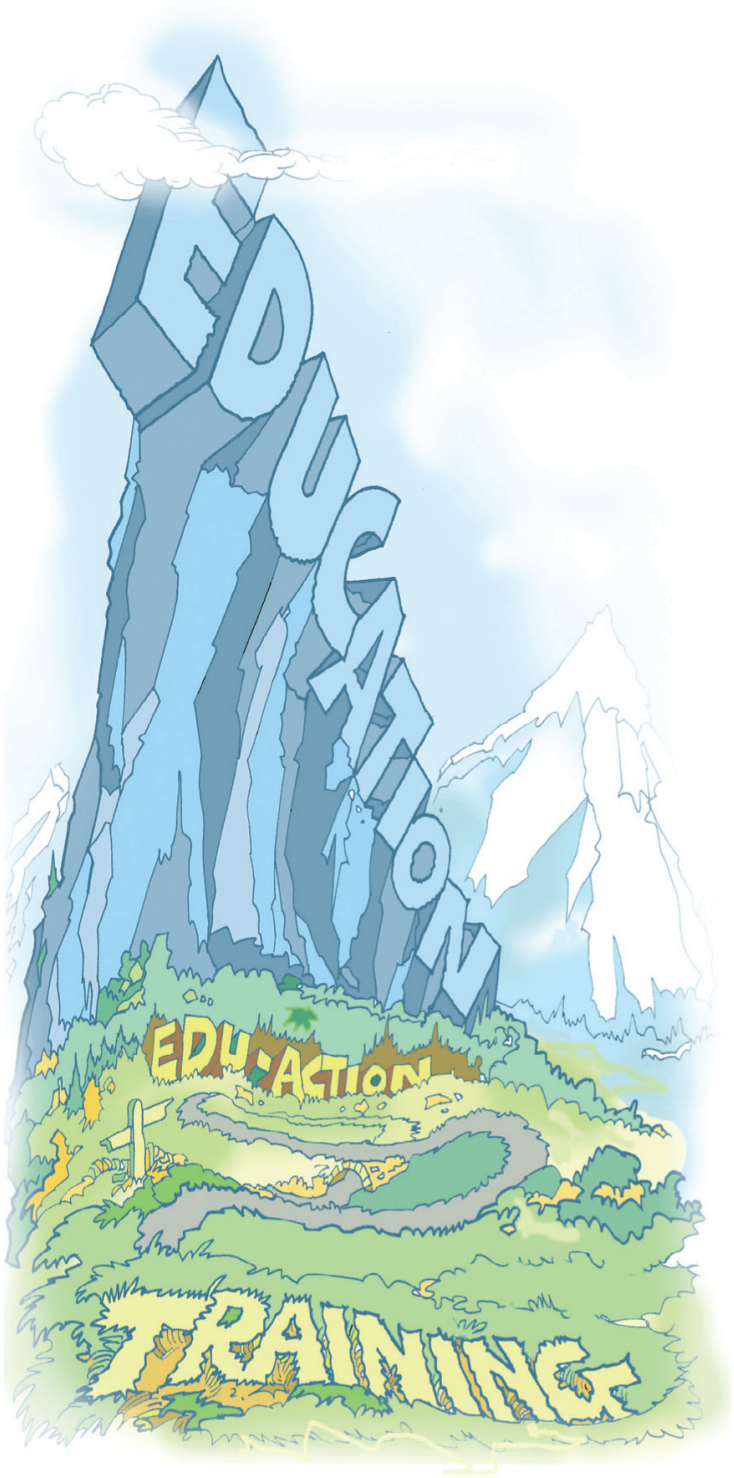
EDU-ACTION

iii. Using *ad hoc* random elements of 'theory'

ii. Doing what teachers appear to do

i. Following tips for teachers (no agency of own)

TRAINING
Adhering to the elements of Training the Trainers
(no agency of own)



This table explains the mountain in more detail (Fish, 2012, pp 40.)

Towards educational praxis and aspiring to principled autonomy: developing enhanced teaching where teacher is their own educational agent	
Engaging in praxis as a life-long journey. **3. Towards educational *praxis***	Is committed to seeking wisdom. Uses practical reasoning to seek the best for the given learner. Recognizes that education is a moral and intellectual endeavour, where achieving the best for the learner is engaged in for its own sake and not for any other reward. Is endlessly exploring the gamut of educational choices available.
Being an educator engaging in educational practice	Can analyze what these learners need (not just want), has an active personal philospohy, sees practice as based on deep educational understanding and professional judgement (how best to act in this situation). Thinks like an educator. Begins to understand self more deeply and develop own character as a teacher. Is own agent.
2. Understanding the nature of education as a practice and self as a person and a professional	Knows about education as well as about teaching. Is aware of own values, has an informed view of what is educationally worthwhile, and recognizes the problematic nature of education. Recognizes that teaching is a moral enterprise with huge responsibilities. Develops, records and keeps under review own personal educational philosophy, and critiques and shares it.
Being a teacher who engages in the practice of teaching	Makes and implements decisions about how to teach, based on some theoretical understanding about the process of teaching, has growing experience, because well-informed about teaching *as a practice*, and thinks like a teacher. Not very aware that teaching is at core a moral enterprise, and that education is a complex concept.
1. Thinking like a teacher	Knows some skills and strategies that teachers use and when, where and why to use them. Knows how to get learners to learn, but does not have own personal basis for teaching. Has thought about teaching but not about self as a teacher.
Edu-action: teaching is a loosely-connected set of *ad hoc* actions and teacher is someone else's agent	
iii. Using *ad hoc* random elements	Has attended courses on some 'theory' that is related to educational practice but has not brought these together into a holistic view of teaching. Does not have a formal theoretical basis for teaching or how to theorize own practice.
ii. Doing what teachers appear to do	Recognizes some key practical issues about how to get learners to learn, but goes through the motions of these in practice, using own best teacher as a model.
i. Following tips for teachers	Follows some commonsense rules, so general as to be useless and dangerous because they can leave the teacher stranded.
Teaching is not seen as a moral enterprise and teacher is someone else's agent	
Training: adhering to the requirements of Training the Trainers	Goes through a given teaching routine automatically and does not engage the minds of learners beyond the basic activity to be learnt.

'Edu-action' is a made up word, denoting something that looks like an educational activity but actually isn't.

Praxis is an Aristotelian term for morally committed action in which, and through which, our values are given practical expression. In other words we are engaging in *praxis* when, in working with our supervisees, we are able to identify all the possible courses of educational action available to us as their teacher, and also we choose and work within the best course of action — the best for them at this time — and do so irrespective of the exigencies of the agendas of all other agents (whose demands we have already taken account of, and whose sanctions and even personal threats we have set aside).

The following table offers a deeper explanation of the important word '*praxis*' and we see this as indicating why it is so important for doctors. In Aristotle's view there are 3 kinds of reasoning, and doctors clearly engage in the form he calls 'practical reasoning', (because all patients are unique and there can be no 'template' or 'blueprint' to follow in respect of deciding what to do for them). Such practical reasoning leads to a form of action which cannot be pre-ordained because the context and needs of each patient are specific. Here, the doctor seeks to do what is right for each patient. The doctor's form of action is thus shaped by a moral commitment to each different patient (as understood by that doctor in that context and seen through the lenses of that doctor's values).

Table 1.1 An Aristotelian classification of *Forms of Reasoning* See Fish, 2012, p. 41 (Adapted from Carr, W. 2009: 60)

Form of reasoning	**Theoretical reasoning**	**Technical reasoning**	**Practical reasoning**
Disposition	***Episteme*** The disposition to seek knowledge for its own sake	***Techné*** The disposition to act in a rule-governed way to make a pre-planned artifact	***Phronesis*** The disposition to act wisely or prudently in a specific situation
Aim ***(telos)***	**To seek truth for its own sake...** Seeking to achieve eternal and pure truth	**To produce some object or artifact (like a chair or a house or some thing a craftsperson has made to *a pre-conceived design*).** This would produce craft, but not art	**To do what is ethically right and proper in a *particular*, practical situation.** The basis of art which includes craft
Form of action	***Theoria:* contemplative action**	***Poesis*: Instrumental action that requires mastery of the knowledge, methods and skills that together constitute technical expertise**	***Praxis:* morally committed action in which, and through which, our values are given practical expression**
Form of knowing	**Philosophy or abstract reasoning**	**Applied knowing or technical reasoning (Greek craftsmen and artisans applied their knowledge — the principles, procedures and operational methods — to achieve their pre-determined aims)**	**Knowledge-in-use or practical reasoning eg: clinical reasoning/ professional judgement/ going beyond protocols — in relation to a specific case**

A1.7 So, who is the person you bring to your supervisory practice?

What are your first thoughts about all this so far in Unit A?

What does all this imply for you as a teacher?

Once you have given it some thought, you need to turn to the following Writing Activity A1 continued

Writing Activity A1 continued: The person I bring to my supervisory practice

Place the above heading for this extended piece of writing immediately following your last piece of writing in the document for Unit A. Be sure to put the date.

Then consider the ideas provided above, and write briefly about yourself using this title, in response to what you have read so far.

Be sure to illustrate what some of the words and concepts offered above mean in relation to your own supervisory practice and what you are seeking to do for supervisees.

Try to set out a cohesive argument that states and supports your ideas and shows how they interrelate.

Do not write more than two sides of A4.

Share your writing either with colleagues or if you are following a module, send it electronically as required only when this Unit is complete to page 43, and bring two hard copies to the taught session.

Section A2:
What is required of me as a clinician who supervises doctors?

A2.1 Introduction

This section is rather more technical in detail. But you will no doubt bring to that detail now a different way of seeing it than you would have done had you begun your thinking at this point.

For example, you are now in a new position in terms of critiquing current requirements. You will be able to think about how the basic requirements are expressed, whether they are explicit enough about the details of what is involved in clinical and educational supervision, and whether the differences between them are made clear enough. You will also be able to begin to critique your current supervisory practice in terms of whether you are fulfilling the new requirements and in terms of the way you are carrying out these responsibilities. You may also need to think about how explicit you are about these matters to your supervisees, and how explicit you should be.

A2.2 The intentions of this section

This section seeks to enable you to:

- be fully informed about the GMC's newest arrangements for the Recognition and Approval of the supervisors of doctors
- know the GMC's educational requirements for this process and how the Academy of Medical Educators has contributed to this
- understand the precise differences between a clinical and an educational supervisor and begin to think about the practical implications of this for your own practice
- ensure that we all share an understanding of the requirements and the differences in principle between a clinical and an educational supervisor.

A2.3 Your own starting point

Before we look in detail at the new requirements and then at how we suggest you might think about the differing roles and responsibilities of clinical and educational supervisors, you should set your own base line by writing formally about how you see these.

Writing Activity A2: The roles and responsibilities of supervisors

Start a new page of your document with a new heading and on one side in continuous prose respond to the following. Don't forget the date.

What are the roles and responsibilities of a clinical supervisor?

How do these parallel those of an educational supervisor, and how are they different?

Is a supervisor also *per se* a teacher?

Is there a difference between supervision and teaching? Does it matter?

A2.4 What exactly are the newest arrangements?

Two documents are currently central to our understanding about the new arrangements for recognizing and approving the supervisors of doctors. As you will see, in General Practice there is already a formal register of supervisors of GP trainees, held by the GMC. Once legislation has been passed the names of all supervisors of doctors in secondary care will also be held in a register by the GMC, where previously they were only held by the Deanery.

The executive summary of the relevant GMC document is provided on the opposite page.

Read this first and then look in detail at those elements of the document that relate to Postgraduate Training, following carefully the instructions in the "Reading and note-making box".

Recognising and approving Trainers: Executive Summary

1. New arrangements for the recognition of trainers will be in place by 2017. The statutory requirements for GMC approval of GP trainers will remain in place. In addition, postgraduate deans and medical schools will formally recognise medical trainers playing four specific roles. (see next page.)

2. The arrangements relate to the following.

   Undergraduate education
   * Those responsible for overseeing students' progress at each medical school

   Postgraduate training
   * Named educational supervisors
   * Named clinical supervisors

3. Therefore, the arrangements will not cover other doctors whose practice contributes to the teaching, training or supervision of students or trainee doctors.

   That essential contribution needs to be properly resourced and supported by local education providers, postgraduate deans and medical schools; but their roles will not need to be formally recognised. The GMC aims to provide regulation that is focused, proportionate and pragmatic.

Reading and Note-making activity

Read carefully the whole of the GMC's 2012 *Recognising and approving trainers: The implementation plan* London: GMC, and any other more recent documents. Access is free on the GMC website.

As you read, make notes of the key points that relate to your work as a supervisor.
If (as is likely) you are both a clinical and an educational supervisor, be sure to note points for both.

Now, go back to each point you have listed and indicate its significance for your own particular supervisory work.

A2.5 The Academy of Medical Educators' (AoME) seven areas that now guide the requirements of supervisors?

The seven AoME areas are:

1. Ensuring safe and effective patient care through training
2. Establishing and maintaining an environment for learning
3. Teaching and facilitating learning
4. Enhancing learning through assessment
5. Supporting and monitoring educational progress
6. Guiding personal and professional development
7. Continuing professional development as an educator.

These relate to the GMC's work on supervision through the GMC's *The Trainee Doctor (2011b)*.

From: *The Trainee Doctor*

'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).

'Trainers must be involved in, and contribute to, the learning culture in which patient care occurs' (paragraphs 6.32–6.33).

'Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees' (paragraphs 6.38–6.39).

'Trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and sufficient time to train, supervise, assess and provide feedback to develop trainees' (paragraphs 6.34–6.37).

The last of these should be noted particularly. The four key roles for which GMC recognition and approval will soon become a requirement are:

1) Named educational supervisors: doctors who are responsible for the overall supervision of doctors in training and their progression during placements. They work with doctors in training to plan their training against the agreed learning outcomes.

2) Named clinical supervisors: doctors who are responsible for overseeing the work of the trainee throughout the placement.

3) Those doctors responsible for overseeing undergraduate medical students' progress. There is at least one in each medical school and, for example, the role may be fulfilled by an NHS consultant or clinical academic co-ordinating the course.

4) Lead coordinators at each local education provider (LEP): doctors who are responsible for co-ordinating the placement training and ensuring worthwhile educational activities.

In these booklets we are particularly concerned with 1), 2) and 4) above.

Reading and Note-making activity

Reading
You should now read the relevant AoME publications. You can access them from the Academy of Medical Educators' web site.

Note-making
Note the key practical implications for you of the GMC's new processes.

A2.6 The key differences between a clinical and an educational supervisor

From the GMC (2012) and AoME (2010 a and b) documentation we can see that:

Educational supervisors are responsible for the overall supervision of doctors in training and their progression during placements. They plan with trainees their training against the agreed learning outcomes.

Clinical supervisors are responsible for overseeing the work of the trainee throughout the placement.

We would take this further by suggesting, following Fish 2012:140, that an analysis of the *educational responsibilities* that Postgraduate Medical Education (PGME) provides for learning doctors, shows the following four main areas of activity.

The four main areas of activity (direct extract: Fish 2012:140).

1. The formal educational programme. This is set within a Trust department and aimed at providing lectures, presentations and group learning. This is often addressed by a variety of 'inputs' on special topics by a wider range of presenters, but it may or may not be immediately relevant to the learning doctor's individual needs in being a practising clinician. Further, the quality of the teaching offered may be variable and is likely to have been conceived as a one-off activity by the presenter. A better way to use this time might be group discussion of live cases and procedures, table-top ward rounds and other ways of probing and developing learners' thinking about current patient cases.

2. The educational/managerial overview. Here the educational supervisor oversees the doctor's learning within a post or programme (where the doctor's overall educational progress is attended to). But such a person does not meet the supervisee on a daily basis.

3. Privileged educational interactions in or near the clinical setting. These are set up to develop the doctor educationally as a person and a clinician on a regular basis. This is where the doctor's main educational needs are attended to directly by their clinical supervisor, guided by the relevant curriculum. ***This is the element that is currently often submerged into the fourth and final category, but ironically is the most important educationally!***

4. Continuous daily clinical supervision. Here, the doctor, as a clinician, is supervised clinically by their clinical supervisor as they work with and for patients in the clinical setting. The supervisor's key role is to oversee the learning doctor's clinical actions, decisions, thinking, and patient management, primarily assuring the safe care of patients. Alertness to diagnosing that doctor's learning needs, as shown up in their practice, and/or to spotting key learning opportunities in what occurs, is also important, but is secondary to patient safety and optimal care. Thus the issues that clinical supervisors highlight in practice need to be attended to in 3. above. [This means setting aside, as soon as possible afterwards, some educational time with the supervisee to follow up the clinical activities experienced in practice.]

The main purpose of these definitions is to be clear as to what is a general programme of presentations for a learner, what is a full educational interaction with a learner and what is primarily a clinical interaction which may be educational at a secondary level or may reveal a learning need to be attended to later. Where this distinction is not clear, learning doctors, who may have the wrong expectations of an event which is primarily clinical supervision, may feel (unjustly) that their education has not been attended to, and that what they have been offered is not 'educationally worthwhile'.

You should note that the whole *Medical Supervision Matters* series will focus on the educational understanding that you need and the practice you engage in as either a clinical or educational supervisor, in respect of 1. 2 and 3. and (as relevant also in 4.) in the box immediately above. The educational principles offered will apply to individual as well as group teaching. Some sections will also focus on the educational management you require in each supervisory role.

A2.7 What are the implications of all this for me?

Writing Activity A2: The implications for me

Return to Writing Activity A2 and please indicate which, if any, of these ideas and clarifications offered in sub-sections A2.4, 2.5 and 2.6 above are new to you. Then, in respect of each of the questions you have already responded to, please add some comments in continuous prose about the implications of these ideas and clarifications for your own supervisory practice.

Section A3:

How do I see virtues, values, character education and professionalism?

A3.1 Introduction

As an educator, a supervisor's influence on the learning doctor is often far more significant than may be apparent. A greater amount of indirect learning takes place via what we call modelling than we tend to realize. Learners read their teacher's attitudes, beliefs, values, virtues and priorities about aspects of their work through their teacher's language and actions. Sometimes they unconsciously copy or take these on. Further, they compare such tacit and unspoken values and virtues with the demands that their teachers/supervisors explicitly make on them as learners. This can mean that the teacher's authority is lost if they appear to apply two differing standards to themselves and their learners.

It is advisable therefore, for all involved in interactions with supervisees to have thought carefully about the virtues and values which they bring to both their clinical and their educational practices. This should include thinking about their responsibilities in character education. This is most significant in matters related to *professionalism*. Being a professional is shaped by our virtues and values.

Further, any teacher inevitably affects, in some way or other, the human flourishing of their learners — irrespective of the details of the specialty they are there to teach. This brings responsibilities to *know what one stands for* in respect of key issues (whilst always being open to developing this), to be more articulate about one's own conduct and to seek continually to enhance it. It is also about being aware of the key virtues necessary to aspire to as a doctor and learning to live them. This needs to be taught not just 'caught'.

As Hansen so cogently says:

> To teach well implies, at one and the same time, cultivating a moral sensibility, enlarging one's person, and enriching one's conduct .... [because we live in a world where teachers] ... can influence others for good rather than for bad ... help them learn rather than become more ignorant, [help them] to form aims and purposes themselves rather than leaving the task up to others, [help them] to develop the skills and talent to accomplish goals rather than being complacent and resigned....
>
> The truth is that in becoming a teacher, a person positions him- or herself to enter and help sustain a world of human flourishing.
>
> (Hansen 2001:40)

A3.2 The intentions of this section

This section seeks to enable you to:

- crystallize the concepts of virtues, values, and character education
- clarify why professionalism matters and what it means to you in word and conduct
- consider what the concept 'professionalism' demands of doctors more generally
- recognize a supervisor's responsibilities to develop a supervisee's professionalism and how this relates to other supervisory requirements including character education
- develop a language to articulate these ideas with supervisees, so as to engage them in exploring and developing these matters.

This will entail supervisors in first asking themselves the following:

- How do I see virtues and values?
- How do I conduct myself as a professional?
- What sort of professional am I?
- What kind of professional should I be encouraging my supervisees to want to be?
- What are the key concepts that need to be attended to with supervisees?

A3.3 Virtues, values and character education

'Virtue is that which makes its possessor good, and his work good likewise'. Thomas Aquinas

Introduction

Here are some ideas about ***virtues*** and ***values*** to get you thinking. Mull these over before you continue to read.

1. What do you ideally regard as the key virtues necessary to be a good doctor?

2. Are there key differences between virtues and values? If so, do they matter?

3. If certain key virtues are a pre-requisite for becoming a doctor, why should a supervisor of postgraduate doctors need to engage specifically in character education? Have their characters not already been formed and their virtues developed by school and university? Or is there something more needed to fit them for service to patients as they practise medicine?

4. Here is a list of specific positive characteristics used as descriptors of doctors involved in commendable medical practice. They come from across a range of key UK medical publications.

- Possessing: Honesty; Trustworthiness; Integrity; Probity; Uprightness
- Being: Compassionate; Kind; Caring; Empathetic
- Having Wisdom
- Having: Commitment; Altruism; and a strong Service ideology
- Being Respectful
- Having Humility
- Being Just; Fair
- Being non-judgemental
- Being Responsible
- Having Courage
- Showing Curiosity

Adapted from James Arthur (2012) 'Virtuous Professions and Organisations', Seminar, University of Birmingham

Not all these are virtues. Can you identify which are? Interestingly the term 'virtue' is not actually used in respect of any of them in the UK medical literature about the duties of doctors. Compare these with those named in *Good Medical Practice* (GMC 2014).

5. In recognizing the difference between knowing about the virtues and being or seeking to be virtuous, Aristotle argued that:

> ...by doing just acts the just man is produced, and by doing temperate acts the temperate man; without doing these no one would have even a prospect of becoming good. But most people do not do these, but take refuge in theory and think they are being philosophers and will become good in this way."
>
> (Aristotle, 2009, *The Nicomachean Ethics,* Book II)

6. McIntyre (2007) in *After Virtue* argued that all professional practices worthy of the name of a practice will have some form of virtue-requiring and virtue-engendering capacity. What do you think this means?

Virtues and Values

For a number of decades the professions and the public have rejected the term 'virtues' and used the word 'values' to talk about the priorities that underlie the behaviour they expect of those in public service. This is about what professionals 'rate' as important and how that affects their visible actions. The metaphor 'rate' here is deliberately numerical because the word 'values' originated in commerce and was originally devoid of any moral overtones. In replacing the term virtues with values, as if the two were synonymous, the discourse of professionals and professionalism has edited out a means of talking about 'goodness' and moral issues more generally — probably because only that which can be measured is now deemed worthwhile!

This in turn has placed a premium on visible behaviour. But such behaviour guarantees nothing about the well-spring from which it comes, as it can be driven by anything from deep personal belief about being a professional to unthinking adherence to trained reactions. Thus this move, from virtues to values in the discourse of medicine (and the professions generally), arguably ignores or hides the truth that working towards the *good* of the patient, requires of the doctor the aspiration to live the virtuous life.

The literature that directs the conduct of medical practitioners in the UK (for example: GMC 2011a; 2011b and 2012) betrays clear evidence of a behaviour-driven discourse. Although many individual qualities that are actually virtues are named within the publications, there is no mention of the *term* virtues in any of them. Perhaps this is because it is (erroneously) seen as referring specifically to spiritual matters and thus is not for use in a pluralistic society. On the other hand, there is also very little in these publications about values either.

This is echoed even in schools — other than those with a religious foundation — the curriculum is explicitly expected to attend to developing the children's values but not virtues. Indeed for several decades in the last century teachers, following Kohlberg's cognitive developmental approach (Kohlberg 1981), were explicitly required to accept and respect the values that children claimed to have (unless they were seriously malign), and not to engage in developing other ideas in them!

It would seem that only now is the danger of all this being visibly laid bare by the work of the *Jubilee Centre for Character Education* at Birmingham University, which was established in 2012. This may be the fruit of what, Annas (2011: 1) claims as 'a revival of interest in virtue and systems of ethics [as] centred on virtue', that has been developing ever since the very end of the last century. She makes the point that this reticence about virtues is despite the fact that in ordinary life we: 'talk all the time *in terms* of virtues' [my italics], labelling people as 'generous or mean', 'helpful or selfish', (Annas, 2011:8).

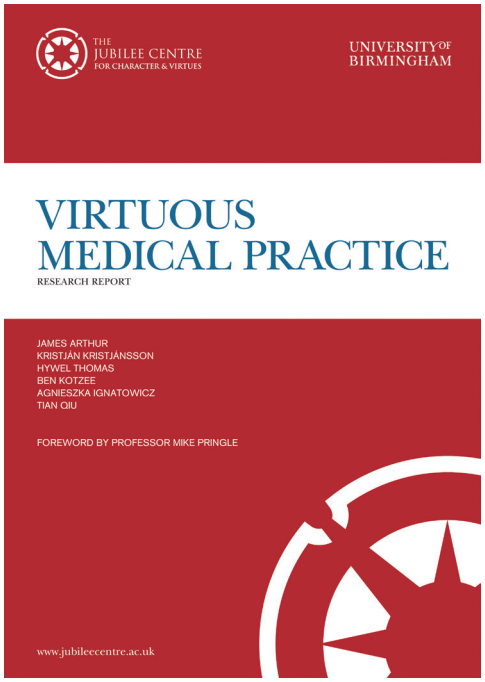
It is ironic that, in medical practice a range of specific virtues is in fact a pre-requisite to entering the profession (as used to be expressed in the Hippocratic oath) and is upheld in daily practice by the requirements of the GMC. And to cap this, the whole purpose of a profession is arguably to provide 'a Good' to society: for example, the purpose of teaching is education; the purpose of medical practice is healthcare; the purpose of the practice of Law is justice. It should be noted that this is emphatically not a claim that such professionals are 'do-gooders', which means someone who while appearing to be helping is in fact interfering and operating for their own gratification, thus lacking sincerity.

Formal Writing Activity A3: A context-specific exploration of my virtues in practice

Write the above heading on a new page in your document and then draw two columns down the page. In the left hand column in bullet points list the stages of a specific complex case you have recently treated. In the right hand column, in the appropriate place, list the key virtues and character traits that you drew on in response to each stage of this case.

Note: You should stop at this point if you are on a taught course!

The Virtues in Medical Practice: a recent report



The recent research report, called *Virtuous Medical Practice* (Arthur, et al., 2015), available at: www.jubileecentre.ac.uk/userfiles/jubileecentre/pdf/Research%20Reports/Virtuous_Medical_Practice.pdf, refers to the various recent debacles in medical practice (Bristol, Alder Hey, Mid-Staffordshire) as evidence for why this whole issue should now come to the fore in medicine and in agendas for medical education. It offers details of research carried out with 'medical students in their first and final years at four UK medical schools, as well as practising doctors and medical educators across the UK' (p. 7). It asked the following key questions:

1. Which virtues and values are held by members of the medical profession in the UK?
2. How do doctors develop these virtues and values?
3. How do virtues and values shape medical practice?
4. How do these virtues and values relate to the expectations of the medical regulatory bodies?
5. What are the implications of virtue-based medical ethics for ethics education in medicine?
6. How can virtues and values be developed through doctors' initial training and continuing education?

The project comprised a mixed-methods, cross-sectional study of the role of character in ethical medical practice, and full details can be found at the above web address.

The report's executive summary offers four points, and emphasizes the following:

- the need for literacy in the language of character and virtue at undergraduate level — and we would add at postgraduate level
- the need to emphasize the important influence of 'role-modelling and workplace culture' on the character development of doctors
- the need for senior staff to 'create more opportunities for reflecting on ethics in the workplace'
- the need for regulatory documents to be clearer about the relationship between virtues and rules
- the need to develop valid and fair ways of assessing doctors' moral character — we would say rather 'to give evidence of' such character.

The resulting responsibilities of clinical and educational supervisors of postgraduate doctors

From this, it clearly follows that the responsibilities of a supervisor in the context of medical education, must be firstly for themselves to recognize the virtues relevant to being a practising doctor, secondly to recognize them in their own practice, and thirdly to understand how they have developed them and continue to do so. These matters are a necessary foundation for working with supervisees to the same ends (which is discussed in Booklet Two). To support supervisors in this, the following three sections offer key definitions, raise significant ideas and a provide a language in which to think about their own practice. The three sections are:

(I) What are ***virtues*** and how exactly do they differ from ***values***?

(II) What kind of education in these matters should be part of postgraduate medical practice?

(III) What is ***character*** and how does it differ, if at all, from ***personality***?

What are virtues and how do they differ from values?

One useful way of thinking about virtues is that they offer universal human concepts that are part of the way of thinking that is common across humanity. The concept of the virtues is understood across cultures and contexts and the language of virtues transcends the individual differences between religions and societies.

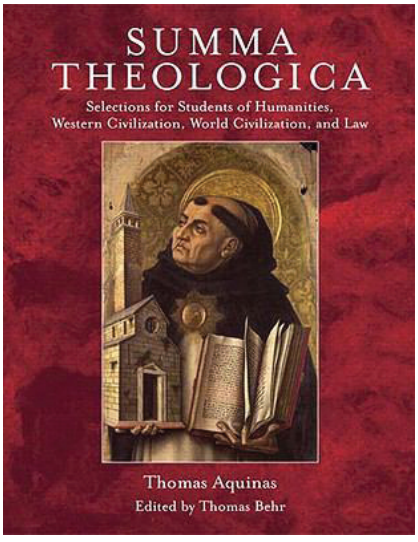
Virtues are shared by us all, and cannot be chosen or rejected at will. For example it would not make sense for a sane person to reject the worthwhile nature of honesty or courage. These may be ideal concepts but few would not treat them as aspirational. But the virtues are not absolutist and cannot be 'required of others'. Further, as human beings we cannot be perfect but we can recognize the ingredients of a worthwhile life and we can choose whether to seek to live it.

Virtues are context-specific in expression and can only be discussed intelligently in relation to an individual in a context-specific example.

Aristotle considered *phronesis* or practical reasoning as the ultimate virtue because it is called upon in the decisions we make about how we engage with all the other virtues. For this reason many philosophers argue that in seeking to lead the virtuous life the virtues cannot be treated as separate character traits some of which we espouse and develop and some we do not care for. Rather to seek to be virtuous is to seek a unified character, though some elements of it may be more developed than others.

These ideas about the virtues (and the demands they make on humanity) embody at heart concepts that are shared and understood by every thinking person, although they are personal in their demands on us as individuals within our own contexts.

The classical virtues (including justice, prudence, temperance, courage) were listed by Aristotle, who believed in the importance of the 'mean' or average rather than the extreme manifestations of virtue or vice. These are also referred to as the cardinal or natural virtues (the term cardinal comes from the Latin word for 'hinge') and they act as the hinge of all our conduct. These were developed into the spiritual virtues through the work of St Thomas Aquinas who explored Christianity in terms of virtues. See also the Appendix to Fish, 2012, in which are listed the virtues in both forms to show their relationship. There are also intellectual virtues.



We can say the following about the virtues, which points have been derived from Annas (2011) and Carr (2007), to both of which the reader is referred. Specific references follow the key points or quotations.

- 'Virtue is dispositional' not temporary: that is, 'a virtue is a disposition of character to react reliably, not a passing mood or an attitude' (Annas 2011:4).
- 'Virtues are principled dispositions that are needed in any culture to offset the excesses to which natural human instincts and inclinations are otherwise prone', (Carr, 2007: 227)
- 'A virtue is a lasting feature of a person, a tendency for the person to be a certain way.' But further, 'it is *active*: to have it is to be disposed to act in certain ways'. (Annas 2011:4)
- It is *characteristic*, in that a virtuous person is acting in and from character, when acting in a virtuous way. Virtue is a disposition central to a character — a deep feature of a person (Annas 2011:9).
- There is a difference between a virtuous person and a virtuous action. In the latter, the person who does a virtuous thing, *may* be doing it reluctantly and against his inclinations and thus not be virtuous at all (Annas 2011:5).
- But: Virtues are not individual traits, 'the development of the virtues [is an] aspect of an overall and unified development of character' ...they form a unity', (Annas 2011: 9).
- 'Someone who discovers in himself an unsuspected capacity to feel and act on compassion, and who develops this capacity, does come to change as a person, not just in some isolated feature; he comes to have a changed character' (Annas 2011:9).
- '(V)irtuous agents are those who — rather than applying general principles in all circumstances – judge what is appropriate in the particular case by wisely weighing moral costs and benefits', (Carr, 2007: 224).

By comparison, the term 'values' which we use to denote our key priorities, comes not from the language of moral philosophy but from economics and commerce. Indeed the term was not used in a moral context until the late 19th century (see the Oxford English Dictionary, OED).

Values are about personal/organizational choices/priorities, and the term is used in at least three different contexts:

(i) it refers to trivial individual preferences that mean nothing to anyone else (like personally valuing purple as a colour above all others)

(ii) it refers to a system of ideas about things taken to be true for everyone but which are not virtues and do not fulfil the above descriptions of virtue (like having a 'can do' attitude; putting the patient at the centre of our business; striving for improvement)

(iii) it is used inaccurately to refer to virtues — as if values and virtues were the same — in contexts in which the term virtues might in some way cause offence by opening up religious argument.

The language of values avoids opening up moral discourse. It provides labels that are descriptors of things we personally see as valuable but they do not have to be shared by everyone as part of a shared purpose in life. Thus it is virtues, not values that would provide a good framework for a publically agreed curriculum, as I argued in Fish 2012.

So, what are the implications of all this for postgraduate medical education?

What kind of education in these matters should be part of postgraduate medical practice?

Postgraduate doctors under supevision (that is, about two thirds of the whole medical staff of most hospitals) need to be motivated to recognize and uncover the Virtues that drive their practice and to develop them, not by learning to 'perform acts that have been independently labeled as virtuous' but by developing 'a disposition [to virtue that] has to

be acquired by habituation' but which 'is not a matter of being habituated to routine.' Annas (2011:4). This is because, as Annas goes on to say:

> Virtue requires not just acting on reasons but having the right feelings and attitudes, doing virtuous actions in an easy and unconflicted way that is characteristically enjoyed'
>
> (2011:5).

She then argues that it is akin to the habituation in a skill, but only 'one in which the agent becomes more intelligent in performance rather than routinized'. I would see this as the difference between being trained in a skill and being educated in a practice, and I would distinguish between *performance* which might not be genuine and *conduct* which is driven by inner belief and understanding. But that difference of emphasis is probably because Annas's practice is psychology whereas mine is education.

She sums her ideas up by saying the following, which could equally be about becoming a doctor *in practice*:

> 'Coming to see that being loyal or brave is a worthwhile way to live is just the first step. Becoming virtuous requires habituation first through our education, both in school and in the family. We are not just told what to do but given role models and encouraged to act in ways that promote and show appreciation of loyalty or bravery. Either in real life or in books or movies we experience (really or vicariously) situations where people behave loyally or disloyally, and we are encouraged to find what makes them praiseworthy or blameable. We need experience to understand what it is to be loyal or brave, and our experience is guided through habituation by parents, educators, and the ways our culture impinges on us'.
>
> Annas (2011:12).

She adds, of learning to be virtuous, that this is about ensuring that the learner understands and achieves 'the ability to do it for herself, and to do it in a way that improves as she meets challenges, rather than coming out with predictable repetition' (2011:20). She notes that: 'We always learn to be virtuous in a given (or embedded) context' (2011:21).

During this process, she argues, the learner will grasp a principle or 'set of principles' and that what is conveyed from the expert to the learner will require the giving of reasons and explanation. This will resonate with supervisors who routinely work in this way, but usually to the end of developing supervisees' clinical practice rather than their virtues.

Character education: what is character and how does it differ, if at all, from personality?

This approach to developing the virtues in learners is often referred to as 'character education' (see Annas 2011; Carr 2007; Kristainsen 2015; Sanderse 2012). Details of the specific aspects of this and how such education might be offered to supervisees will be found in Booklet Two. But we have to ask first: can a teacher change personality? Should they even try to do so? Or does 'character' mean something different?

Broadly, personality refers to the more innate dispositions, temperaments and mindsets that we are born with or have been deeply caused in us by some means, and which are unlikely to change. Personality can be categorized as a psychological type and probably only psychiatrists should engage with this. By contrast, our character is the expression of the collection of traits that drive how we conduct ourselves, as a whole person, with others in the world. These are developable throughout life. Character is about who we are and how we see ourselves, what we have been persuaded to adopt as our *modus operandi*. Thus character can be developed and shaped by education.

However, the distinction is not a bald one and there are probably aspects of our being that are part personality and part character. Carr makes the point that:

> There can be no moral imperative to make ourselves witty, vivacious or cheerful, and we cannot be blamed if (by dint of natural temperament or social conditioning) we fail to develop such qualities – whereas we may be praised for developing honesty and self-control or blamed for our malice or sloth. That said, it is often difficult to draw clear lines between features of personality and traits of character, and we may sometimes be hard put to know whether to attribute an agent's sympathy or generosity to personality or character.
>
> Carr (2007: 230)

Indeed, he suggests that perhaps the key differences 'turn on' choice and effort. Thus, he argues that 'natural' generosity is not virtuous until it has been 'submitted to the discipline of practical wisdom' (where the person involved can give evidence of and reasons for their appropriate choice of conduct within a given context). This involves developing an awareness of how our actions can be driven by acknowledged principles and articulated values, so that our character or *personhood* is expressed in our conduct. Such education might thus offer the learner new ways of thinking and of being, that challenge previous ones.

A3.4 What is professionalism? Does it matter?

As we argued in Fish and de Cossart (2007), professionalism is an aspect of practice that is assessed in all doctors at all points from the Foundation Years to the end of specialty training. It is significant in shaping good relationships with all heath care colleagues. It is recognized by the sick as central to the quality of their care, and is a crucial element in patients' attitudes to their doctors. The Royal College of Physicians' (RCP) 2005 report on the importance of medical professionalism sees it as underpinning the trust that the public has in doctors and states: 'Patients certainly understand the meaning of poor professionalism and associate it with poor medical care'. It continues: 'The public is well aware that an absence of professionalism is harmful to their interests', (RCP, 2005: xi). Professionalism, then, is also a critical factor in the consideration of clinical governance and in medico-legal situations.

But what is meant by professionalism? All practising doctors believe that they know what is involved in being a professional in today's National Health Service (NHS). However, the professional ideals, aspirations and values that drive practice are far from easy to unearth and express clearly. As a consequence, doctors have until recently mostly been content to leave them as implicit or even tacit. However, it has now become clear to the medical profession that it is vital that 'doctors must be clearer about what they do and how and why they do it,' (RCP, 2005, xi).

It is therefore important that doctors in training are enabled to explore, make explicit, defend and critique the key principles, virtues and values to which they aspire and which they intend to use to shape their working lives as medical practitioners. Further, it is equally important that they are then helped to find the courage both to explore their practice in terms of these virtues, (identifying where their aspirations do not match their actual conduct), and explore the virtues they aspire to in terms of what medical practice currently allows or encourages. The gap between one's aspired virtues and those that are found in one's practice as well as the gap between how one is permitted to practice and the virtues one wishes to aspire to, will indicate aspects of one's conduct and one's views about professionalism, all of which need in some way to be worked upon critically.

A3.5 What does professionalism mean to you?

For all of us, our professional values are how we consistently see the world in which we engage in professional practice; and what we prioritize in our professional life. They shape how we conduct ourselves in the clinical setting and in supervisory or other educational practice. For all of us there is sometimes a gap between our espoused values (values we claim to hold) and our values-in-use (values that emerge from our practice).

A key example of this would be the failure to prioritize educational activities in the light of a target-driven culture, where one view of what professional practice is about (ie the rapid through-put of patients) blinkers its proponents to any other view, and (we would argue) this is threatening the quality of both education and healthcare. Alternatively, we may sometimes have to concede that our espoused values are unable to be achieved in the current situation, that the case to prioritize them has not been made, that we need to find a compromise position, or that they are truly inappropriate. (But we do not think that this is true of the above example — even in the short term.)

This requires us to continue to ask:

What kind of a doctor do I want to be? (espoused professionalism)

What kind am I now? (professionalism in action)

Such questions, like the ideas in the following section, are useful not only for teachers to ask of themselves (which it is advisable to do before using them with a learner), but also for talking with supervisees about these important matters. They allow a slightly more constructive approach to these issues than is achieved by beginning with a negative example of a supervisee's conduct.

A3.6 Exploring professionalism

The design of the prompt (or heuristic) that follows was first published in Fish and de Cossart 2007. It has been based on ideas developed in 1974 by Eric Hoyle, which he originally offered at the point at which teaching became an all-graduate profession. We use it here as a set of ideas that, like a springboard, can free readers to explore their own professionalism. Its intention is to encourage practitioners to recognize and move on from a narrow to a broader view of what is involved in being a professional.

A simplistic approach to using this heuristic should be avoided. For example, it should not be assumed that the restricted professional is always the new member of the profession and the extended professional the more experienced member. Young and new doctors might be extended professionals while older but narrower thinking staff might be restricted ones. Further, it is most likely that most people are somewhere on a continuum between two given polarities, and are more extended in respect of one continuum category than another.

The important ideas to explore, prompted by this heuristic, relate to the views professionals hold of what is (or should be) involved in their daily conduct as professionals.

Professor Mike Golby said that professionals are:

> persons who seek a broad understanding of their practice, paying attention not only to their developing competence, but also to the fundamental purposes and values that underpin their work.
>
> (Golby, 1993:5.)

Now look at the chart on the following page and, thinking about an example from your practice that you are proud of, highlight your own position along each horizontal set of categories. Then try to discuss your findings with a colleague of similar experience to your own.

Extended professional	Restricted professional
Sees the expertise of a doctor as developed through experience, reading and reflection	Sees the expertise of the doctor as simply defined by the contractual obligations of their employment
Sees the nature of clinical practice as eternally evolving, which requires a problem-solving approach and educational development, especially in respect of professional judgement	Expects the detail and nature of clinical practice to be laid down by outside agencies, which requires the application of protocols through training
Sees the doctor as bringing everything they can offer to the therapeutic and holistic care of the specific patient	Sees the doctor almost exclusively in terms of their technical competence and specialist knowledge in respect of a part of a patient's body
Engages in practical reasoning in which all knowledge, thought processes, actions, and personal attributes are harnessed in the service of the individual patient's case	Engages in technical reasoning and rule following which requires objectivity, and absolves the doctor from engaging in complex thinking and using professional judgement so often
Recognizes that practice is interpretive and that a doctor's own values and philosophy will inevitably colour that interpretation	Considers practice to be based on objective knowledge and does not see the significance to practice of own professional values and philosophy
Sees medical practice as a moral enterprise	Does not focus on the moral obligations of clinical practice
Understands that the wisdom of medical practice is dependent on the quality of the professional judgements made on the spot in relation to the given context	Does not value professional judgement. Values only that which can be measured.
Sees accountability as giving an account of the choices available and made, in a given situation, and the personal philosophy that drove these	Sees accountability as about conformity to the requirements of external authority, which excludes choice, and simply requires rules to be followed.
Concerned with long- as well as short-term goals and considers wider social context and later times. Places value on professional collaboration and development at local and national level	Only interested in short term goals — survival and getting on with the job. Sees clinical events in isolation from each other and ignores the significance of any wider perspectives and professional development
Reads frequently in a wide range of literature relevant to professional practice generally Redraft of: Fish and de Cossart, 2007, p. 86	Derides reading as something active practitioners do not need and do not have time to try to understand. (See www.ED4MEDPRAC.co.uk)

A3.7 Thinking further about professionalism

The term 'professional' has been subverted by society at large to characterize anyone behaving well, irrespective of the job they do. This is so, even to the point where the media talk of 'professional fouls' in football and even describe a murder as 'carried out very professionally'! Ironically, at the same time the work of the professions has come in for considerable criticism.

For these reasons, when talking with supervisees, it is advisable, instead of using the word 'professionalism', to talk of 'membership of a profession'. This brings with it characteristics that are not applicable to those in other jobs, and highlights requirements and responsibilities that those who are not members of a profession do not have to fulfil.

The following box explores the implications of this in some detail, and could be a useful resource in discussing some of these more difficult matters with supervisees. Indeed, the whole of this section can be useful particularly in working with supervisees whose values and views of professionalism do not accord with your own!

Membership of a profession (See Fish and Coles 2005 and Freidson 1994)

A profession is an occupation. It is specialised work by which a living is gained.

But it is more than an occupation. It is work for some 'Good' in society (education, health, justice).

A member of a profession exercises a 'Good' in the service of another, and engages in specific activities which are appropriate to the aims of the service.

The service that a member of a profession renders a client cannot entirely be measured by the remuneration given.

Members of a profession have a recognized theoretical basis, to their practice and draw upon a researched body of knowledge.

Work by a member of a profession is: esoteric, complex, discretionary, requiring theoretical knowledge, skill and professional judgement that ordinary people do not possess, may not wholly comprehend, and cannot readily evaluate.

Professionals have an ethical basis to their work. This is about much more than having a code of conduct to follow. It is about having to make on-the-spot judgements and engage in actions that are immediate responses to complex human events, as they are experienced. (That is: professionals create meaning on the spot in response to a complex situation.)

This brings with it the moral duty for the professional to be aware of the values and virtues (personal and professional) that drive his/her judgements and actions and the duty to recognize and take account of them as part of their on-the-spot responses.

Being aware of one's personal and professional virtues and values is therefore vital.

It also brings with it the need for some autonomy of action. This needs to be circumscribed by the traditions within which professionals are licensed to practise.

The capacity to perform this service depends upon retaining a fiduciary relationship with clients. ('Fiduciary' means that it is necessary for the client to put some trust in the judgement of the professional).

In the public interest, professionals also need to have a commitment to life-long education.

This raises important questions about how to enable someone to learn professional practice.

As we said in de Cossart and Fish 2005, we believe the current demands upon professionals to achieve performance targets are leading to the erosion of these traditional ways of working and being. We would argue that the current demotivation of senior members of professions is probably related to this. Young professionals, those considering a professional career, and those involved in their education, need to give careful thought to this changing world and its effect on the development of the professional practitioner of the future.

Other resources for working on professionalism with supervisees are the GMC's *Good Medical Practice*, (2011) and the Royal College of Physician's *Doctors in Society: Medical Professionalism in a changing world* (2005). One of the best books we know is Creuss, Creuss and Steinert (2010).

The written clarification, regularly updated, of a profession's values:

- provides the public and professional regulators with explicit parameters of professional conduct, which can be currently expected of members of that profession
- provides educators of new entrants to the profession with the basis for helping them to recognize and scrutinize critically the values of the profession they are joining
- provides intending entrants to the profession with a basis from which to consider their own values and the relationship of these to those of the profession
- provides teachers, learners, assessors, evaluators and the profession with one starting point for the rationale for professional education
- provides curriculum developers with a proper basis for ensuring that all the key elements of the curriculum fully support the values of the profession and the consequent needs of learners
- provides examiners and assessors with the basis for deciding the purposes of assessment, what should be assessed, and how
- provides all relevant parties with a properly explicit basis for review, critique, and development of the curriculum itself.

Readers should note that these ideas can help in the formation of a statement of their own professional philosophy.

Note-making box

What does membership of a profession mean to you?

What issues about professionalism would you seek to discuss with your supervisee and how would you go about this?

Section A4:

How do I construe the nature of clinical practice & why does this matter?

A4.1 Introduction

As a supervisor, your way of seeing and thinking about clinical practice, about the status and nature of medical knowledge and about patients, not only shapes your own conduct as a clinician and your own well-being as a professional, but are crucial in influencing your supervisees' attitudes and beliefs about their own clinical work, the knowledge they are assembling and the patients they work with, as well as their depth of understanding about how clinical practice works and what its challenges are.

That is why, we would argue, it is the responsibility of all supervisors to know how they see these matters and understand their complexity, so as to help learning doctors to gain a realistic grasp of what is involved in the practice of medicine and to grow and flourish as persons and professionals.

That is why this section (A4) tackles the first of these, and is followed by a section on medical knowledge (A5) and one on patients (A6). Of course, there are some who would argue that the supervisor's job is merely to offer clear and simple advice about the practical aspects of patient care in their current attachment/post. We would argue that professional practice is not as simple as that, either in respect of clinical work, or of teaching, and that to see either or both as so simple is to be a restricted professional as discussed above.

We believe this booklet provides support for the privilege of stopping to think more deeply than usual about these issues and bringing to the surface your tacit views about things you daily take for granted. By this means you will be able to articulate your own views more clearly when working with supervisees and have in mind more explicitly some of the dilemmas and choices that have to be faced in daily practice.

A4.2 The intentions for this section

This section seeks to enable you to:

- think about how you see the nature of clinical practice
- consider the implications of this for how you *think about* your supervisory work
- explore the implications of this for the way you work with a supervisee.

Note-making box: How do you see the nature of clinical practice?
Characterize it in key words and phrases

A4.3 The context for clinical practice

We would argue that clinical practice is carried out within a complex context which cannot be fully experienced as a medical student and which doctors 'in training' need to become much more aware of once they are qualified, in order to practise intelligently. Fish and Coles (2005) discuss the need of curriculum designers to understand and make explicit this context, as part of designing educational programmes for becoming an expert doctor. But what they have to say is equally as important for anyone setting out as a supervisor of postgraduate doctors.

The chapter tackles interesting questions about the context in which doctors work, explores what is meant by 'a practice', introduces notions of professional judgement (to which we shall return later) and also discusses professionalism using ideas you have already met. In so doing, the authors have drawn on various kinds of evidence to illustrate the expertise of doctors in relationship to the context in which they work.

Now read Chapter 5 from Fish and Coles (2005) and make brief notes for yourself to capture the key characteristics and issues discussed and relate them to the specifics of practice in your particular specialty.

Writing activity A4: The context for clinical practice, the nature of practice and the implications for me as a clinician and a supervisor

In the light of the above reading activity complete the following, on the next new page of your Unit A document.

Use the title provided above, and write in continuous prose where possible, using bullets as appropriate, but always lead into these with a prose sentence that tells the reader what you are offering in the list.

1. List briefly the main points the authors make about the key characteristics of the context for clinical practice.

2. Discuss those aspects of the context of your practice which are of particular importance to your own specialty practice.

3. Say how you might help a supervisee to come to recognize these and understand them better.

Then read Section 5 (over the page) on the nature of practice and add further to your writing by:

4. Listing what you see as the most central characteristics of clinical practice itself, as experienced in your own specialty.

5. Discussing how these might best be taught by a supervisor.

A4.4 The nature of clinical practice

An allied matter, and one that the chapter you have just read mentions, is how the character of clinical practice itself might be described. The box below offers some notes on this, which go a little further. Think about each bullet point before writing your own comments at 4 and 5 above.

What is involved in the work of professionals?

The reality of the lived clinical experience is more multi-faceted than simply being about getting the patient better.

It involves the processes of **differential diagnosis / treatment plans / care pathways**, but what lies under these?

Immediate and highly informed judgements, often have to be **made on the spot, in collaboration with fellow professionals — in relation to the traditional practices and values of that profession**, about, and **in the service of, vulnerable human beings**.

It uses a mixture of **intuition**, professional **on-the-spot judgement, hunch and risk-taking**.

All of it is **informed by esoteric and complex procedural and propositional knowledge***, shaped by a recognition of the **moral dimensions and the importance of the Virtues**, controlled through the traditional **professional parameters for shaping proper conduct,** and influenced by the need for **accountability.**

And **although one can illuminate the knowledge embedded in a piece of professional practice, one often cannot fully express it in words.**

In many senses this involves **creativity, and is based upon practical wisdom** (which is more than mere accrued and repeated experience, but rather is experience reflected and deliberated upon until the deeper understanding of that practice has been achieved).

Such work cannot (except in trivial matters) be satisfactorily categorized in tick boxes.

It is about **communicating with and working with colleagues, multi-professional team work, and knowing and being able to assess one's own strengths and weaknesses.**

And ironically, the propositional **(factual) healthcare knowledge** called upon in any one interaction with patients **is often a small proportion of the whole knowledge drawn upo**n. It is necessary to know it and to know when to use it, but it is actually one of many resources all of which need a place in the curriculum for practice.

Professionals are members of **a range of professional communities, in each of which the professional has responsibilities to his/her fellows. This makes professional practice (and the learning of that practice) a social and collaborative enterprise. Such professional communities include the community of the work-place; of one's specialist knowledge; of one's professional body; and of professions generally.**

In short:
Professionals endlessly create, negotiate and develop meanings; have to be appropriately flexible about some things and inflexible about others; affect others and are affected by them; engage all the time with multiple activities, factors, perspectives; endlessly create and develop problems and solutions; and categorize and learn to live with the insoluble, the ephemeral, the tentative, and the incomplete. (de Cossart and Fish, 2005: 100)

* But see p.61 below
Remember, you not only have the right, but even the duty to respond critically to these ideas and then to write about your own ways of seeing this (as required in Writing Activity A4 on p.57).

Section A5:

How do I view the nature and status of medical knowledge?

A5.1 Introduction

There is considerable informal evidence that many medical supervisors often make highly un-informed and entirely tacit (unspoken and therefore un-clarified) *assumptions* about the nature of knowledge and knowing — and don't even know they are doing so!

Medical knowledge has certainly, in the last few decades at least, had the highest status amongst that which medical students must 'master' before gaining their medical qualification and that practising doctors in training then must demonstrate further through their Royal College examinations before being able to complete their training satisfactorily. As such, much energy and time is spent on this, almost to the exclusion of the other matters (like understanding self, one's professional identity, one's understanding of the context of practice and of the nature of clinical practice and the Virtues that are required in medical practice) — matters that we are already beginning to uncover as central to developing into a wise doctor, but which are often left as subliminal.

This section explores different ways of seeing and thinking about what we mean by 'knowledge' and 'knowing'. It explores what supervisors and other medical teachers often unconsciously assume about what is called 'knowledge transfer', and what Paulo Freire (1972) has called the 'banking concept of knowledge'. Here we relate these ideas to medical practice and explore how the knowledge that medical students have gained as undergraduates becomes re-organized once they are in full postgraduate practice.

All these matters have profound implications for how you teach your supervisees. Even as you begin to share any new knowledge (medical or otherwise) with your learning doctor, you will inevitably already be conveying how you think about what it means 'to know' and about what can be claimed as 'true', and thus will be influencing your learner about matters that go far beyond the specifics you are offering.

As Francis Bacon said in 1612: 'knowledge is power'. It can enslave you, or emancipate you. In sharing it with learners, teachers who have not examined their own understanding about knowledge and its power can unwittingly wreak havoc in their learners' minds and unknowingly implant misinformation about, and unhelpful attitudes towards, medical knowledge, thus enslaving them.

Having said this, it must be emphasized, that none of this is to undermine the importance of doctors' medical knowledge and its vital and central significance in treating patients safely and optimally. It is merely that whilst knowledge is necessary, it alone is not sufficient, and that how supervisees are encouraged to see **epistemology** (the *nature of knowledge*) also needs attending to.

A5.2 The intentions for this section

This section seeks to enable you to:

- acknowledge a variety of ways of thinking about the nature of knowledge ('epistemology')
- recognize your own assumptions and beliefs about 'knowledge' and 'knowing' in general and how they relate to belief and understanding
- see how these shape the way you think about and carry out your medical practice
- understand the implications of all this for the practice of supervision
- note the differences between how medical students and doctors in practice organize and draw upon their medical knowledge.

A5.3 Your own starting points

Note-making activity box: (responding in writing helps you to think!)

Write brief notes in the space provided in relation to each of the following statements. Indicate whether you agree or not by marking the box appropriately and then say why.

- If I tell someone something, then of course, they will automatically know it. ☐ tick or cross
- If they don't then know it, there is something wrong with them. ☐ tick or cross
- It is possible to 'give' someone your knowledge by transferring it to them through lectures and power point presentations. ☐ tick or cross
- Knowledge (and especially medical knowledge) is absolute and unchanging. ☐ tick or cross
- There is one simple step from 'not knowing something' to, 'knowing it'. ☐ tick or cross
- Having knowledge means believing and understanding something. ☐ tick or cross
- Knowledge is something that lies in books and in 'knowledgeable' people. ☐ tick or cross
- Knowledge is 'theory', skills are practice. They are separate. ☐ tick or cross

Again, how supervisors construe these matters (consciously or otherwise) is highly significant for how they teach supervisees and the subconscious attitudes they tacitly and uncritically inculcate in them.

Some further comments

The following offers some points to help you consider this further.

A) **Knowledge is not necessarily unchanging and absolute.**
The general view of empirical knowledge is that it is substantiated by solid research evidence which can be relied on. Yet research is always finding new evidence some of which contradicts earlier 'knowledge'. This is partly because even scientific research knowledge involves human interpretation — which by its very nature is disputable.

B) **Knowledge can be categorized in various ways.**
It can be seen as simply divided into theory (**propositional knowledge**) and practice **procedural knowledge**). The idea here is that propositional knowledge deals with facts that are ascertainable from various recognized sources of knowledge (books, people, the internet) some of which are more reliable than others, and many of which do not entirely agree with each other. Procedural knowledge, by comparison, is about 'knowing how to do something'.

Some argue that the real division of knowledge is between theory on the one hand, and practice on the other, and that they are separate though both are needed in medical practice. The first half of this statement can be supported by ideas about the essential differences between 'knowing something in theory' and 'knowing it in practice'. However, when probed further it becomes clear that while we are doing things, we are also drawing on ideas and thinking such that theory underlies practice, so that they cannot be thought of as unrelated *in practice*. However even this isn't all the 'truth' because it is possible to do things practically without any knowledge of the underlying theory. (Riding a bike, for example, does not require underlying knowledge about the laws of balance or even the laws of gravity, since 'experiential knowledge' accrued through doing and thinking about that doing, is all you need.)

This raises yet further questions about whether the Western World's way of talking about knowledge, in which the word 'theory' always precedes 'practice' is necessarily correct. And if this is in question (as it was thousands of years ago in the East), we have to ask whether in professional practice we *always* have to learn theory before we can practise. Indeed, the notion of **'theorising our practice'** is itself an important one (otherwise how would we ever learn to do new things and then pass that knowledge on?) Indeed you might note the way this booklet is constructed, in that we have chosen to highlight the practice choices that supervisors have to make and then to offer some theoretical insights that might enlighten those practical decisions. In this way, theory becomes a servant to practice, not its master.

From all this, we learn to be both sceptical and critical about the way these words are used and to refuse to accept unconditionally the ideas that traditionally lie beneath them.

This means that we should note that any way of dividing knowledge is man made, and that the traditions and history of how these have come about do not mean that they are unchangeable. For example: how did the various divisions of medicine come to be? Who has decided what constitutes the separate medical specialties and sub-specialties that we have today? Were these categories always in existence? Will they be in future?

C) **'Knowing' is a weasel word because 'knowing something' can mean very different things.**
Knowing something is not at all the same as understanding it. Knowing can be about little more than broad recognition ("I know the Queen", because I know what she looks like). Or it can mean something as deep as understanding and believing it to be true. Ironically, it cannot really mean anything more than that. That is, it cannot guarantee that something actually *is* true.

D) **How we learn new knowledge is itself a matter of dispute.** Some see knowledge as 'out there' ready to be learnt, some see it as to be constructed by each individual for him/herself.

You should now read the section on 'epistemology' in the Resources Booklet. You may then wish to go back and add a little more to the notes you made in the note-making activity box.

A5.4 The implications for supervisors

So what are the implications of all this uncertainty about knowledge for supervisors of doctors in postgraduate professional practice? Before asking you to engage in a writing activity that addresses this, we would like you to read the following extracts from two very significant writers: Paulo Frieire and Gordon Wells. Why don't you check them out on the internet?

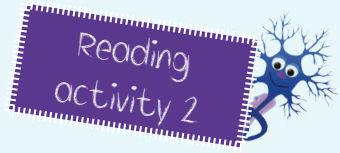
Paulo Reglus Neves Freire, Ph.D was a Brazilian educator and philosopher who was a leading advocate of critical pedagogy. Born in 1921, he died in 1997 in Brazil. He became familiar with poverty and hunger during the 1929 Great Depression. In school he fell behind and his social life revolved around playing pick-up football with poorer kids, from whom he learned a great deal. These experiences would shape his concerns for the poor and would help to construct his particular educational viewpoint, which is highly political.

First published in Portuguese in 1968, *Pedagogy of the Oppressed* was translated and published in English in 1970. The methodology of the late Paulo Freire has helped to empower countless impoverished and illiterate people throughout the world. Years before he was 'invited' to leave his homeland after the military coup of 1964, Freire had begun devoting his life to the advancement of the fortunes of the impoverished people of Brazil.

Paulo Freire extract from *Pedagogy of the Oppressed, Chapter Two, pp.52-67.*

Read the extract from the work of Freire, which provides you with an important reference point for what is called the 'banking concept of education'. As you read this extract ask yourself:

- What exactly is Freire saying about two different ways of seeing education?
- Might the fact that the context for this piece is both geographically remote from the UK and very politically motivated, alter our response to Freire's ideas?
- What, exactly, does this extract offer you as a supervisor of postgraduate doctors?



Gordon Wells extract in A. Pollard (ed) (2002) *Readings for reflective teaching,* pp 235-37.

Read the brief extract from the work of Gordon Wells and ask yourself the following.

- What does Wells say about how learners need to make sense of knowledge for themselves?
- How does the fact that much of his work is with children affect its importance for supervisors?
- What might the implications of these ideas be for supervisors of postgraduate doctors?

Note-making box:

Write some bullet points about your own reactions and response to what you have learnt in this section

A5.5 One more perspective on knowledge: how novices and experienced doctors use medical knowledge of facts and procedures

In discussing the nature of medical knowledge, Fish and Coles argue:

> There is substantial evidence that doctors use propositional knowledge differently at different learning stages in their postgraduate careers.
>
> For example, the knowledge that novices call upon is largely scientific in nature and has been structured for them in text books and lectures which, being largely theoretical, highlight the intrinsic structure of the academic discipline from which they have come.
>
> Few teachers in medical school invite learners to re-structure this for themselves ….
>
> By contrast, postgraduate doctors gradually have to discover how to re-package their knowledge to enable it to be drawn on quickly and appropriately in their everyday clinical practice. Schmidt and Boshuinzen (1993) set out a model for considering the difference between novices and experts in their use of knowledge.
>
> They say that being an expert is not necessarily knowing more than novices but having learnt to organize knowledge differently, combining it with increasing experience of cases, until the cases become more significant than the scientific knowledge.
>
> Eraut and du Boulay (2000), referencing Chang et al. (1998), point out that as the postgraduate becomes more experienced, there is evolution of both knowledge *structure* and diagnostic skill. Further, they seem to suggest that in postgraduate medical practice, new ways of structuring the knowledge already possessed become more important than accruing large amounts of new propositional knowledge. For example, increase in *knowledge* of patho-physiology is small compared with the reorganization of what is already known in order to make it more readily and rapidly available (see Eraut and du Boulay, 2000: 1.1).
>
> They also remind us that every practitioner's knowledge base is highly individual and will have evolved from their previous personal clinical experience. But it is Cox who puts all this in perspective when he says: 'it should be remembered that expertise lies not in the knowledge *per se*, but in the judgement of what's pertinent and important' (Cox 1999: 277).
>
> **Fish and Coles, 2005: 143-4**

The literature on this is extensive. A few examples include: Chang, Bordage and Connell (1998); Cox (1999); Eraut and du Boulay (2000); Schmidt and Boshuizen (1993).

Section A6:
How do I see patients and the relative priorities of patient care and supervision?

Note: You should first remind yourself of the notes you made on page 30 above

A6.1 Introduction

We argued in Fish and de Cossart, 2007 that learning doctors need to come to an informed view about what kind of relationship with patients they should strive for. Their ability to create nurturing relationships (or not) with their patients will shape their whole professional life, making it meaningful or leaving it devoid of something inexpressible yet significant. Creating such relationships with all patients, irrespective of one's instinctive personal response to them, can be worked upon and refined once we understand what this is really about. This is important because, whether or not doctors are conscious of it, the visible elements of their work daily express how they see patients in relation to themselves, and, significantly, patients in turn are highly skilled at recognizing this.

Patients are vulnerable. No matter how much they know about themselves, their symptoms and sometimes their diagnosis, they have to have doctors to confirm their disease, to offer them treatment and to provide 'more than a presence but skill, and not just personal concern but highly disciplined services targeting on specific needs' (William F May, quoted in Campbell 1984, p. 92). However strong patients are in their suffering, it usually reduces their stamina and weakens their belief in themselves. By contrast, doctors are powerful as result of, their skills and knowledge; they have the physical strength and staying power of the fit; and they are highly motivated to cure, improve or, at minimum, palliate, the sick.

The GMC makes it very clear in many of its publications that good and safe patient care lies at the heart of a doctor's moral responsibility, and that this lies at the centre of supervisors' work. Thus, it is a foundational plank in the GMC's recognition and approval process that supervisors attend to this with their supervisees (GMC 2012). This means that all supervisors need to engage in four major enterprises in respect of patient care.

1. They need to have considered carefully the virtues, values and beliefs that drive their own conduct in respect of patients and their valued supporters, so that they can be articulate as needed on the spot about how they themselves see these matters and can sensitively open up to discussion the serious and sometimes difficult matters of how doctors relate to patients.

2. They need to have interrogated their own practice for themselves, to see how their intentions in respect of all this relate to what they actually do, and how they decide what is appropriate in the particular context — especially in difficult cases.

3. They need to model in their visible practice, and openly invite critique of, their actual concern for both patient safety and the care of the whole patient as appropriate in the particular context.

4. They need to be able to explore with their supervisees how they see these matters, to look with them at particular examples of their conduct with patients, to guide them as appropriate and to help them formulate how they should be conducting themselves.

The other side of this coin, of course, is that since the safe care of patients has always been seen by doctors as paramount, supervision and other educational activities for learning doctors are sometimes sacrificed on the altar of 'service work'. Yet *both* are priorities and how we balance them will have profound and long-lasting effects upon learning doctors. *Good supervision is, in itself, a means of ensuring good and safe patient care for the future*. How we value supervision and postgraduate medical education more generally, will profoundly influence the supervisee's attitude to it, and ultimately affect the quality of their education as well as patient care.

None of this is a simple matter. Working with patients — and with supervisees — is in both cases highly dependent on the sensitivities and moral sensibilities of all involved (patient and doctor, and the supervisor and supervisee). Teaching someone *to care*, and be actively compassionate cannot be done by giving them a lecture. How supervisors conduct themselves as clinicians and educators is a powerful means of teaching, particularly if their conduct and the underlying Virtues that drive it are then open to discussion and critique.

Further, it is better for supervisors to embark on such discussions already having had a prior private opportunity to think these things through explicitly first so as to have to mind the key arguments that need to be made. It is also good to have some resources available in hand to prompt supervisees to think for themselves. In addition to this booklet, supervisors can develop their own resources by having thought through (or written about) some of their own clinical cases. (Further discussion of this follows later.)

Accordingly, this section will give you the opportunity to make some preparations for those spontaneous occasions when you need to talk with supervisees about their conduct, and will help you to probe the subliminal messages you convey about how you value medical education, and your view of what makes a virtuous doctor.

A6.2 The intentions for this section

This section seeks to enable you to:

- explore and make explicit your own ideas and beliefs about patients and patient care, in preparation for a sensitive discussion of your conduct and its underlying drivers
- consider how you construe the relative priorities of patients and their care and supervisees and their learning, and *how you attend to this in practice*
- investigate your own practice, with a view to exploring with supervisees how you model patient care
- prepare for exploring with *your supervisees* how they see patients and patient care, and how they conduct themselves in respect of this is practice.

A6.3 Making explicit the ideas and beliefs that drive your own conduct in respect of patients and their valued supporters

Montgomery (2006: 162) says that when the doctor/patient relationship goes well it is '*one of the triumphs of human society*' (p162). But, of course, it is a triumph only when the relationship has at its heart the plight of the sick patient not just the cure of the disease. Cure is not always possible and might be described as the bonus in the relationship, to be handled with humility rather than triumph.

In our own writing Linda and I reserve the term 'therapeutic' for the very special relationship that indicates the mutual *working together* of a wise doctor who brings a range of qualities and a patient who is willing not merely to meet the doctor, but where appropriate to reveal to the doctor 'the particularity of their case and the individuality of their being'. Such a 'willingness', must depend more on how the doctor meets the patient, than on the character of the patient. (see Fish and de Cossart, 2007: 168).

In order to achieve this, the doctor has to pick his or her way through a number of complexities and ambiguities. Wisdom is not gained overnight. Neither is it without cost. But, wisdom — and its expression in the therapeutic relationship with a patient — does provide an ideal to aspire to (and sometimes to reach). And that is perhaps, even more important than ever, in this 21st century world of 'liquid modernity' (Bauman 2000 and 2004) and risk aversion (Neuberger 1996).

Such an approach to care involves a commitment to each patient, which (though not limitless) certainly involves active concern, a will to work with, rather than on, the ill person, and a kind of open-ended helpfulness (Campbell, 1984, p.104), or 'intelligent kindness' (Ballatt and Campling (2011). This arguably requires balancing commitment to the patient, to all other patients, and to a duty to self. This involves 'disinterested

love' or *caritas* (a valuing of the other that takes full interest in them, without personal gain of any kind — including seeking a reputation for wisdom); and respect for every person's dignity and rights. Patients also deserve consistency of care, which means both continuity of care and a high standard of care and as current events have been showing in the last few years, such continuity seems less valued by managers and is only maintained where doctors fight for it. (See Fish and de Cossart, 2007; Fish 2012.)

This personal commitment to key Virtues cannot be captured solely in the current language of the 'contract'. It is a relationship that goes beyond 'codes of conduct'; or guarantees of trustworthiness as safeguarded by professional codes of ethics and the disciplining of those whose conduct lies outside the acceptable. Campbell (1984: 104), offers instead the term 'covenant' which avoids calculation, promises active concern and involves altruistic motivation and the earning of trust. But, none of this is straightforward. At the heart of being a wise doctor is a judicious balancing of: (i)the demands made on him or her (ii)the motivations and ethical principles that a doctor brings to his or her practice (iii) and the doctor's ability to recognize, navigate through and resolve (temporarily), the ambiguities inherent in 'serving another'. (Fish and de Cossart, 2007:168.)

Using these comments and following the prompts in the box below to help you, make some initial notes about how you see all this.

Note-making box:

In your experience, what does a patient actually want from you, their doctor?

What makes for a good doctor / patient relationship?

What is your role in relation to each patient you treat?

On what basis do you decide what is best for the patient?

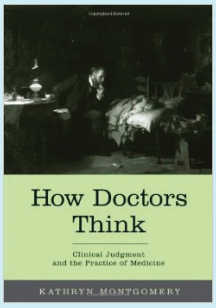
What Virtues guide your conduct in making a relationship with a patient?

How do you think about the patient's personal valued supporters?

Please read the following extract as a further prompt to help you to think more precisely about what you believe about these matters.

This reading that we invite you to consider was first cited in Fish and de Cossart 2007. It provides a useful reminder that it is not only the patient but also their relatives with whom a doctor often needs to interact.

Extract 1: Kathryn Montgomery writes in How Doctors Think (2006: 206-207)



"This is a book that will be read with pleasure by anyone interested in how medicine is done and it is a book that should be required reading for all students starting their clinical training."--Journal of the Royal Society of Medicine
"Montgomery has certainly written a piece that will stimulate people to think more deeply about medical and wider health professional practice. It is a text I will recommend to students and colleagues."—Psyc CRITIQUES

A year after my child's diagnosis, five months after her treatment ended, I didn't care about scientific fact or epidemiological probability. I heard a surgeon long in practice tell me my daughter would not die of breast cancer, and all the studies and statistics, the questions and the data that I used for months to dismiss attempts to placate me died in my mouth. I leaned back in the passenger seat. It wasn't politeness or (except maybe for a split second) deference to someone who was giving me a ride to meet her. Instead I was silenced by his assumption of a clinical responsibility. It was not certainty he offered but his best judgement and the grounds on which he based it. It felt as solid as certainty and somehow more valuable because certainty, I knew, was not to be found. The situated particularity of his clinical judgement and, especially, his openness about its limits was oddly enough what made him trustworthy. Ironist that he no doubt was, he was not asking me to believe the facts but him. Besides, her treatment was over, it was time.

In the next moment, I began to believe him. Something hard and despairing in me settled, quieted and then let go. "Thanks", I said provisionally, hearing it from a long way off—. Then, unexpectedly, I saw that soon I would mean it with my whole heart.

Now return to the notes you made at the start of this section and add some more comments in another colour.

A6.4 How you see the relative priorities of patients and their care, and supervisees and their learning, and *how you attend to this in practice*

A supervisee once told Linda that she had given her no teaching on an aspect of clinical practice that they had faced together and talked about regularly in clinical practice throughout the trainee's attachment. It turned out that she meant that she had never sat in a classroom where Linda had given her a lecture on it. This raises deep questions about the following:

1. **Is clinical supervision a form of teaching or not?** Is teaching something that only happens in a classroom? (How can teaching and supervision not be the same, when the supervisor is providing opportunities in practice to think about as well as act upon real clinical issues? After all, we have said that thinking and theory are not separate from doing and practice. Surely what matters here is that both supervisor and supervisee understand that this is so.)

2. **Isn't it possible, therefore, that clinical practice for safe and good patient care can occur**

simultaneously with good education for the supervisee? (This can and often does happen, so that to assume a divorce between the two is over simplistic. However, additional time at another point may also be needed as there will not always be time on the spot for the appropriate detailed educative explanations. But to assume that the two priorities are always in conflict is inaccurate.)

3. **Is there really any relationship between education and good or better patient care?** My response to this would be in the affirmative, providing that the education offered was of an enhanced quality and not simply treated as a technical matter.

The following table, from Fish (2012) offers a way of seeing this and the explanation of this then follows. Look at the table and see what it says about two very different approaches to teaching and their impact on patient care. It uses the term 'instrumental' to mean basic, simple and quick ways of getting teaching done, where 'enhanced' means made richer by more thoughtful methods.

Towards a shared purpose in PGME for better patient care (Fish 2012: 23)

Instrumental approaches involve the following	Enhanced teaching approaches involve the following
Teaching Telling a learner quickly what to do to care for the patient, and then just getting on with the job. This treats the learner as a worker to be instructed. (This is unlikely to impact on improved patient care.) **Assessment** Teacher completing a traditional national assessment form, without exploring the case with respect to the learner's understanding of the deeper issues raised.	Engaging with a learner in thinking deeply about specific patient care (reflection *in* and *on* action in cases and procedures). Engaging in a detailed discussion about and assessment of patient care and also the learner completing a record of their clinical insights gained from this process.
Teaching Telling a learner to improve their professionalism. **Assessment** Using the assessment forms to indicate that this needs to be, or has been, attended to.	Seeking to nurture the learner as a doctor who knows who s/he is as a person and a professional (developing, character, disposition and the capacity to know oneself). Reflecting orally and in writing on *professionalism* and Virtues as drawn on in action with patients.
Teaching Telling a learner to do *it my way* — like this. **Assessment** Using the assessment forms to indicate they can 'do it as they have been taught to'.	Helping a learner to adapt the knowledge and skills they have learned in the classroom to safe and caring patient care, across a range of patients. Reflecting orally and in detail on what they have learned through patient cases about themselves as well as medical practice.
Teaching Telling a learner how to relate to patients in a range of contexts (including breaking bad news) — by training them in communication skills. **Assessment** Using the assessment forms to indicate this has been attended to.	Supporting a learner as s/he develops their own therapeutic relationship with a wide range of patients. Reflecting orally and in writing on what they offer in interpersonal relationships with patients and the complexities/problems, the ethical and moral issues and the sensitivities that arise.

What can be seen from this table is that the instrumental approach (on the left), represents what the learning doctor is told to do, which is then assessed simply for whether or not they can do it. This can produce a young doctor who is dependent on their senior as the person who controls their doing, thinking and even 'being' in the clinical setting. This does not readily produce a pro-active, thinking expert on whom any Healthcare Provider can begin to rely, to provide best patient care whatever unexpected difficulties occur within treatment. The instrumental approach produces the kind of doctor who is best only at following known pathways and often does not develop the flexibility, creativity and confidence in self that is needed when treating patients who themselves readily discern what their doctor brings to their care. It seems fair to claim that teaching doctors in an instrumental way which equips them only for the expected and predictable, may have led to the unease found currently — amongst doctors, managers and patients — about what junior doctors can actually do!

By contrast to this, enhanced teaching (together with its approach to assessment), as seen in the right hand column, can cultivate a doctor who is learning '*to think* like a doctor' and '*to be*' a doctor, in the fullest sense. This is education in its truest sense. A learning doctor under this approach can bring for detailed discussion, exploration, development and refinement with a senior, their own current knowledge and understanding, their own ways of seeing things, and the person they are as a doctor. What they can then offer to patients is a doctor who responds person to person to the patient as an individual with particular health needs, such that almost whatever happens, they can provide for their needs — effectively, efficiently and with the kind of humanity that patients particularly recognize and value when they meet it. This in turn means that the doctor and patient can work together and contribute together towards the best treatment possible. Such a state of affairs is also likely to reduce complaints and to contribute to the Healthcare Provider's reputation for quality care. Further, this may well cost *no more*, requiring only the reorganization of time and resources. In fact, if the safety and improvement of patient care really matters, Healthcare Providers need to recognize that they cannot afford *not* to engage with this approach to educating their doctors.

What are your views about this?

Note-making activity warning!

At the end of this section you will be asked to write two to three sides of A4 (single spaced in Ariel 12 point) about the educational implications for supervisors of how they and supervisees see patients.

For now you should pause and collect notes (in bullet points) in response to what you have read so far.

Giving it space and time: how do I value supervision in relation to safe patient care?

Review the last full week of your normal clinical practice and on one side of A4 construct a timetable for each day on which you indicate how you have spent your time between: patient care in direct contact with patients or their clinical context; paperwork and administration with managers or alone; supervision (specify how many supervisees, when, and for how long, and the activity you were both involved in); and any other educational activity — including your own professional development.

Were there any occasions during this week when you set out to engage in either supervision or any other educational activities and either did not get there at all or truncated the time you intended to

give the supervisee in favour of something 'more important'. If so, say what activity it was that prevented you from attending or extending the supervision/educational activity.

Note-making box:

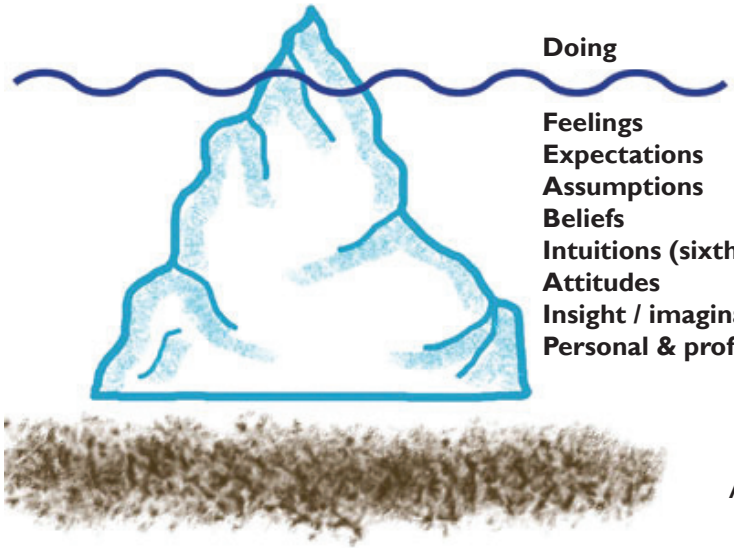
Write notes about what this says about how you actually value the process of supervision.

A6.5. Investigating your own practice with a view to exploring with supervisees how you model patient care

As we have said, much of this aspect of medical practice cannot be taught directly, but rather is modelled for the supervisee in the practice setting. Look at the picture here and think about what it tells you about a good doctor patient relationship.

Examples of specific cases are always useful to have in mind for educational purposes. The following two activities are designed to help you make explicit and record both how you have worked with two specific patients who for particular reasons required more sensitive than usual care as a person and how you responded to that.

Recognizing and making explicit that which lies beneath the surface of our conduct is not easy. Use the following picture prompt (or 'heuristic') to help you. It uses an iceberg as a metaphor for thinking about what lies beneath the visible surface of our practice as professionals. You might note that that a version of this diagram is to be found in the Foundation Curriculum.



Adapted from Fish and Coles, 1998

The words down the right hand side can be used as a guide to the various aspects of the person you brought to a particular patient. We would ask you not to use this in a stereotypical way to characterize yourself or anyone else in general as we are different in different cases. (This is a point worth discussing with your supervisee)

Writing Activity A6 Patient A and Patient B

Your Patient A

In respect of a particular recent patient case chosen because you were caused to think more specifically than usual about the Patient A **as a person**, write a brief reflective account of the case, (about two sides of A4) focusing particularly on them **as a person** and how you related to them and what they needed as a person from you, the doctor. Use the iceberg heuristic as a prompt.

Try to list the key Virtues that drove your conduct in this case.

Then think about how you might best share this with your supervisee and to what particular educational end or goal in relation to doctors relating to patients, and write a paragraph about this.

Your Patient B

In respect of a particular recent patient case where the patient was particularly difficult for you to relate **to as a person**, write a brief reflective account of this case, (not more that 2 sides of A4) focusing particularly on **them as a person** and how you related to them and what they needed as a person from you, the doctor. Use the iceberg heuristic (or prompt) to help you.

Try to list the key Virtues that drove your conduct in this case.

Then think about how you might best share this with your supervisee and to what particular educational end or goal in relation to doctors relating to patients, and write a paragraph about this.

Jamie Fanning writes:

Music to soothe the soul

It was the weekend, as it usually is, and the patient was added to the emergency theatre list for a mini-laparotomy and insertion of gastric feeding tube. What I initially assumed to be a straightforward case soon transpired to be quite the contrary.

On the ward I met a relatively young gentleman, just into his 60s. On talking to him I discovered that he had recently been diagnosed with terminal throat cancer, having presented a few weeks earlier with weight loss and dysphonia - a worrying feature for the anaesthetist, triggering 'difficult airway alarm bells'!

In that instance, my intuitive-reaction was one of "what are we doing here, we will kill him with the anaesthetic". This was based, experientially, on my immediate knowledge of standard anaesthetic approaches for this procedure which would likely result in a loss of his airway and ultimately his death...!

Despite my belief, I spoke to the patient and very quickly it became clear that, in spite of the significant risks which we had discussed in detail, he was determined to undergo the operation as this would allow him to receive palliative chemotherapy which in turn would facilitate his discharge. As a career-long pub DJ, it was his dying desire and driving motivation to get home and visit the pub where he had worked for so many years, to drink a cold pint with his friends - his family.

Knowing his wishes and valuing his right to influence his own care, I worked collaboratively with the surgeon and the patient and we agreed to proceed under local anaesthetic — a somewhat unusual approach to an open abdominal procedure. Ultimately, we successfully carried out the operation using local anaesthetic, along with lots of talk and reassurance and with my role being DJ, rather than anaesthetist, playing his favourite songs loudly, on his request, through the surgeon's iPod speakers.

Interestingly, despite my apparent lack of anaesthetic input into this patient's care, for a teacher within postgraduate medical education this case has proved to be a sound educational resource. It offers me the opportunity to engage in rich discussions with trainees, pitched to their level of experience, regarding:

- knowledge: anaesthesia for abdominal surgery, throat cancer – anaesthetic implications, local anaesthetics (pharmacology), risk factors predicting a difficult airway
- skills: pre-operative assessment, difficult airway techniques/management of the failed airway
- legal: informed consent, discussing risk (to patient), litigation (risk to anaesthetist)
- clinical thinking: risk assessment/reduction, clinical thinking, anaesthetic decision making, considering the patient, their values & beliefs and the clinical context, complex case management, best interests assessment
- professionalism: professional values and Virtues, assumptions/attitudes, conduct in the workplace, communication with patients — honesty, professional conversations with colleagues, patient-centred care — less can be more.

A6.6 Preparing to explore with your supervisees how they see patients and patient care, and how they conduct themselves in respect of this in practice

From the thinking you have just engaged in for the two writing activities immediately above, it will already be clear that whenever we write down how we construe aspects of and issues related to an example from our practice, and also how we think about our action in that practice, the writing we do will:

- extend our own understanding of ourselves and of clinical practice
- capture something concrete that can then be discussed further at a range of levels for a range of educational purposes by a range of people.

For example, it might be interesting to think about what a manager within your practice who read your two pieces might learn about the complexity of your expertise. Thus the value of this sort of written exploration to a range of parties should now be beginning emerge.

We hope you will now agree that engaging a supervisee in an open and honest discussion of how they see patients and how they relate to them is an important but also a sensitive responsibility, and that offering our own practical and moral struggles in respect of this may be one way into it. We would argue that, difficult though they are to teach, such matters carry a weight of importance alongside and as part of the initiation into medical knowledge, practice, and the profession's traditions and routines, all of which are indisputably central to the work of a supervisor.

In summary then, drawing on this section as a whole and other creative ideas of your own that you might have, use the box below to make notes about some of the options available to the supervisor as a means of enabling supervisees to talk openly about:

- how they see and relate to patients generally
- what they expect to bring to them of themselves as a person
- how they manage themselves in relation to difficult patients
- how they maintain a discrete and discreet distance from patients they are attracted to
- what they think a patient wants from their doctor
- what Virtues they see as necessary to cultivate further in relation to patient care
- anything else that this section has raised for you.

Find a way to share these with other colleagues at your own level and then try them out over time with your own supervisees.

Note-making activity (see above)

cont..

Note-making activity (continued)

Section A7:
Review: How do I now see supervision?

A7.1 Introduction

This section will leave you with more questions than answers and will act as a link between this Unit and Units B and C. In the previous six sections of this Unit, you will have faced many of your own inner uncertainties about being a supervisor and will have begun to see anew at the level of principle what supervisees ought to be offered within their developmental programmes.

In Unit B we shall turn to the specifics of how to decide exactly what to teach, when, how, and why and in Unit C we shall look at supervisees and what they want and need and at the process of learning. Just before that, however, it is time to review your ideas so far about what supervision is and should be about. For example: should we see supervision as the same as teaching?

There are no easy answers to any of this, and the best response to them is usually context-specific. That is why we style these matters as 'dilemmas'. Recognizing that facing dilemmas about what any supervisor needs to be, know (understand), think, do and become, is key to successful supervision.

A7.2 The intentions for this section

This section seeks to enable you to:

- explore the nature of supervision and the relationship between it and teaching
- probe the dilemmas in deciding what kind of a doctor I am seeking to be and to nurture
- begin to consider what you need for your own development as a supervisor.

A7.3. Exploring the nature of supervision

Supervision (whether clinical or educational) requires direct interaction with an individual supervisee (even though you may, in the clinical setting, work with them in a small group). Supervision provides the opportunity:

- for the supervisor to relate to an individual, who needs to learn from them and their expertise: by talking one-to-one; by engaging in clinical and/or educational activities with them or in front of them; by sharing practical experiences that can be reflected upon together
- for the supervisee to discuss the patient and practice rather than the disease and theory, and/or share their personal sense of their own progress and how their educational programme works for them.

This is powerfully different from what happens when the individual learning doctor is amongst a crowd and in a more formal educational setting. Of course both are needed, and we would argue that they are two sides of the same educational coin. Both are about the *continuing education* of the supervisee and both involve not simply 'managing' the 'trainee' but actually educating him/her. Much of the current literature about the requirements of clinical and educational supervision presents it as merely about educational management (de Cossart and Fish, 2013). But educational management is about — but only about — providing the *structure* that enables and supports the practice of education.

It is perhaps out of respect for the seniority of the learning doctor as both a postgraduate and a practising professional that this is all couched in terms of 'supervision' as if it were somehow a different and more superior activity than teaching. But the use of the terms 'trainer' and 'trainee' suggest that this is a form of interaction that is less than education and is also rather degrading to the doctors involved. Supervisors of doctors assess them and follow a set curriculum. They are clearly more than mentors who advise.

Supervision tends to mean 'one who oversees the tasks of another'. So far, this seems

reasonable though couched in language that is not very professional. The term 'clinical supervision' is used across all kinds of professions — but, please note that — in differing contexts it comes with all kinds of different nuances of meaning that adjust the relationships involved and intentions of the role in which it is used and the status of the personnel involved. In general, it describes a practitioner meeting regularly with another professional, to discuss casework and other professional issues in a structured way. The word 'structure' here indicates that there is intentionality involved. Advice given and debates held do not just arise unexpectedly, spontaneously and in isolation, as they would if it were simply a colleague sharing ideas with another colleague during work. Where there is educational intention, about interactions that occur on a formal basis over a period of time, then that becomes teaching.

Further, of course, in medical practice, unlike any other profession, supervisors teach and assess the 'supervisee' on a nationally set curriculum throughout the first 7 –14 years of their practice — such that failure would mean the loss of progression through the normal career.

We shall explore this further in Unit B, where we look at differences between seeking to educate and setting out to train, and look at how these terms relate to supervision.

A7.4 Probing the dilemmas in deciding what kind of a doctor I am seeking to nurture

Whatever else a supervisor teaches, advises or communicates to a supervisee, there will always be left in that learning doctor's mind a highly influential sense of what their supervisor believes about what — in the final analysis — makes someone a good doctor.

This will be so, irrespective of whether the supervisor has ever sat down and faced the question explicitly and articulated their own ideas about it, let alone discussed it openly. The idea of what makes for a good doctor will always be subliminally if not explicitly at the very base of everything the supervisor does with, does in front of, and says to their supervisee.

So what are the possible ways of construing what is meant by 'a good doctor', from amongst which we as supervisors have wittingly or unwittingly already chosen, and/or which we might wish to revise our views about once we have considered the matter?

Here are just two of many ways of thinking about this, offered in order to help you begin to formulate your own.

1. The good doctor as knowledgeable expert

Such a doctor is often seen as deeply knowledgeable about medicine and technically efficient. Here the assumptions and mindset are:

- that what must drive good clinical practice is knowing in depth and breadth the empirical knowledge necessary to 'do the job'
- that such knowledge is the mark of fitness to be a doctor
- that this is all about clinical expertise
- that safety in medical practice is having a pathway that will lead you to the truth and the right way to do things
- that what is required in the treatment of patients is a focus on the disease and the necessary scientifically driven response to this.

2. The good doctor as wise practitioner

Such a doctor focuses not only on the skills and knowledge that are necessary to being a good doctor, seeing these as although absolutely necessary yet not sufficient alone in themselves to ensure good patient care. They distinguish between 'having the knowledge' and 'proving this' through examinations on the one hand and having such knowledge but also 'developing understanding' such that they can serve patients as humanely and fully as possible, on the other. They attend in their professional development additionally to:

- knowing and understanding consciously the very roots of who they are and what they stand for as medical professionals

- knowing and understanding themselves as human beings as well as professionals
- needing to be able to articulate honestly 'what they do and why they are doing that'
- understanding in detail the Virtues as drivers of their own conduct, and practice
- recognizing that they need to be their own agents in the service of their patients and not merely an enactor of laid down protocols
- needing to be sensitive to the particularities and humanity of each patient such that they can establish a therapeutic relationship with them
- needing to have the capactity to engage in sound and rigorous thinking and decision-making and to make wise judgements in the 'white heat' of practice
- needing to be able to see beyond the immediate focus to the wider perspectives of medical practice.

The follow-up question is, of course, once we have begun to clarify the vision (or rather educational AIM of postgraduate medical education in general and supervision in particular): how should we seek to go about helping to develop these qualities?

In the first example (number 1 on the opposite page) of course, it is fairly straightforward. The supervisor supplies advice and information and trains the supervisee in skills and procedures as appropriate and as required. In the second example, we would argue that such a neutral, objective and relatively impersonal approach can never happen, because there will always be 'indirect teaching' (also known as the hidden curriculum), in which the teacher's attitudes, values and beliefs, though tacit, will inevitably come through the interaction with the learner, and as a result, will shape more than the skills and knowledge. Indeed, we would argue that surely PGME (of which supervision is a part) should seek to develop in the learning doctor at least the following:

- a sense of professional identity and professionalism (knowing and understanding consciously the very roots of who we are and what we stand for as medical professionals)
- sound clinical thinking and wise judgement (knowing and understanding what we do, why we do it and what drives this)
- criticality about all matters
- flexibility of thought and the ability to continue to learn
- clear thinking in respect of arguments
- a well-calibrated moral compass (recognizing and understanding the very drivers of our conduct)
- an ability as part of our being, to meet patients, whole person to whole person.

A7.5 Summarizing your own developmental needs as a supervisor as you now see them so far

Look back over the whole of Unit A

Look at what is involved in the daily work of your chosen supervisee and what you currently see as the key aspects that you need to attend to with them.

Writing Activity A 7 My developmental needs as a supervisor

List those matters you currently need to attend to in your own professional development as a supervisor.

List your current developmental needs as a supervisor in the light of Unit A

Try to find a colleague to discuss these matters with.

Congratulations! You have now completed Unit A

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