

# Educational supervision, personal support and mentoring

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## Aims

This paper:

- Introduces some of the national issues and concerns about the provision of educational supervision, mentoring, academic guidance and personal support
- Provides an introduction to the principles underpinning the provision of guidance and support to students/trainees
- Explores some of the issues concerned with the role of the teacher
- Identifies how these principles can be incorporated into developing effective and supportive learning environments

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## Introduction

The role of a teacher often comprises much more than simply turning up to deliver a set lesson and then going back to another administrative or clinical activity. In Higher Education and in clinical learning, teachers are expected to take on a wider range of roles than ever before and their activities are also subject to evaluation and scrutiny.

A number of reports and guidance documents are available relating to the support and supervision of undergraduates, postgraduate and trainees. This paper aims to bring together some key points from some of these documents and to highlight some of the key issues and principles of good practice.

The paper will also look at some of the formal and informal mechanisms which exist to support students and trainees and at some of the ways in which clinical teachers can help to provide timely, appropriate and helpful support, guidance and supervision to their students and trainees. It will describe some of the different types of support that teachers can give or facilitate, such as educational supervision, mentoring, academic guidance, tutoring and counseling, and consider some of the similarities and differences of such roles and support mechanisms. Finally the paper will look at how teachers themselves might define the boundaries and limitations of their support and at some situations in which teachers themselves may need to seek help.

## A note on terminology

Throughout the paper, the term '**guidance**' is used to mean a cluster of activities relating to a focus on decision-making about learning ie. educational guidance. The term '**support**' is often used in relation to the wider aspects of learner support, which may include study skills, IT skills and library services, but here we are focusing on the provision of academic or personal support given to individual students, trainees or groups by clinical teachers. Support and guidance often involves giving **advice**, offering **supervision**, acting as an **advocate** or **mentor** and employing **counseling** skills, but we are not looking here at professional counseling services.

## The national context: issues in HE and the NHS

The provision of effective support systems for learners at all stages is necessary, not just to create a good environment for learning but because the provision of effective and timely guidance and support can help in the retention of students, junior doctors and other health professionals. Many of the reasons that people leave university and the health professions are not simply academic, they feel unsupported, isolated and under stress. This is particularly important at times of transition: such as the first year at medical school, starting the PRHO year, the first year after graduating in the health professions, when changing jobs or having been promoted.

Take a look at the extract from *Mentoring: Theory and practice* below which highlights some of the issues for newly qualified nurses.

The National Board for Nursing, Midwifery and Health Visiting for Scotland has recently published a guide to good practice in preceptorship (NBS, 1999). The guide identifies four models of support: specifically prepared preceptorship programmes; orientation or induction programmes; telephone support; and staff development programmes.

The NBS guide includes examples of statements made by newly registered practitioners which demonstrate the value of support schemes (Gray, 1998):

“I was very proud on my first day, being employed and being in my white dress, I felt I had really earned it after 3 years ... It was the worst day of my life because everywhere I went somebody wanted to know ‘what am I having this for?’ and I was thinking please don’t ask me questions today.” (Louise)

“For the first 3 months I was going home in tears everyday because it was so busy and I felt so unsupported ... I felt at the time that things were going too fast for me and I didn’t know what to do. I thought, right I don’t want to be a nurse.” (Fiona)

In an article about an 18-month support programme for newly qualified nurses offered by the Birmingham Heartlands and Solihull Trust (Field, 1999), Angela Field shows how regular contact with senior nurses and training in clinical activities can improve recruitment and retention. The 18-month programme was developed after identifying key themes during interviews with third-year nurses. Three factors emerged from the interviews:

- the need for comprehensive support systems
- the need for structured development opportunities
- the opportunity to rotate around a variety of clinical areas.

Universities and postgraduate deaneries are very aware that support for students and trainees is necessary at all stages of a doctor’s career but we also know that many students and trainees struggle and do not receive the help they need.

The Higher Education Quality Council (HEQC) produced a number of reports and guidance documents which included guidelines on academic guidance, personal development and student support. These set out a framework for guidance, support and counseling which is still highly relevant for teachers in HE and in vocational education and training today.

**The key principles set out in the Guidelines on Quality Assurance (HEQC, 1996) are as follows:**

1. Systems for student support should focus on enabling learners to take personal control of their own development, by providing opportunities for the exercise of choice, decision-making and responsibility within a supportive environment, in order to promote the development of autonomous learning.
2. Educational, personal and vocational guidance should be committed to and demonstrate ethical ways of working, offering impartial, confidential support and advice, available and accessible to all students, at all ages, from pre-entry to programme completion and career decision.
3. Guidance arrangements should rest on an assumption of equality of opportunity for all students, with additional resources and strategies invested in those students who are likely, for whatever reason, to be disadvantaged in their learning or career development.

Another major work in HE was the DfEE's Guidance and Learner Autonomy Project carried out during 1994-6 which was based on some common assumptions:

- Guidance is primarily a learning, rather than a helping, process
- It is normal and proper for all learners in HE (both students and staff) to require guidance from time to time, to explore ways of learning to meet the challenge of change
- The fundamental ethic of guidance is based on the interest and autonomy of the individual learner
- Guidance is not the exclusive role of specialist staff

The General Medical Council (GMC) has defined the attributes and key activities of a medical teacher in *The Doctor as Teacher* (GMC, 1999). In *The Doctor as Teacher*, the GMC reminds teachers that they have responsibilities for the supervision of students and trainees: "every doctor should be prepared to oversee the work of less experienced colleagues and must make sure that students and junior doctors are properly supervised" (para. 5, p. 2). The GMC goes on to define the personal attributes of the doctor with responsibilities for clinical training/educational supervision and note that these include "sensitivity and responsiveness to the educational needs of students and junior doctors".

Although the GMC does not explicitly discuss the provision of guidance and support for juniors and students, many of its guidance documents include an implicit assumption that clinical teachers will provide support for juniors. The GMC did however define some of the issues concerned with guidance and support in the reports on the informal visits carried out to medical schools between October 1998 and April 2001, during which the GMC Education Committee reviewed the undergraduate and PRHO programmes at all UK Schools. The new version of, (2002), the recommendations on undergraduate medical education, sets out four main recommendations on undergraduate student support, guidance and feedback. These are:

**GMC recommendations on undergraduate student support, guidance and feedback  
(*Tomorrow's Doctors*, GMC, 2002)**

- Students must have appropriate support for their academic and general welfare needs at all stages. Medical schools must produce clear information about the support networks available, including named contacts for students with problems. Students taking special study courses that are taught in other departments or by other medical schools, and those on clinical attachments at sites that are not close to the medical school, must have access to adequate support.
- Medical schools must stress to students the importance of looking after their own health, and encourage them to register with a GP. They must tell students about the occupational health services, including counseling, that are available to them.
- Medical schools must give guidance about the core curriculum, SSCs and how their performance will be assessed. This should include information about practical arrangements for assessments and the medical school's policy on students who cheat in examinations. Students must be able to get academic advice and guidance from identified members of staff if they need it in a particular subject.
- Students must receive regular and consistent information about their development and progress. Clinical logbooks and personal portfolios, which allow students to identify strengths and weaknesses and to focus their learning appropriately, can provide such information. Using these will emphasise the importance of maintaining a portfolio of evidence and achievement which will be necessary once they have become doctors and their licence to practise is regularly revalidated. Feedback about performance in assessments helps to identify strengths and weaknesses, both in students and in the curriculum, that allow changes to be made.

The principles and comments describes above enshrine good practice, and probably all teachers would subscribe to these as core principles, but what do they mean when put into practice?

**Thinking point**

We can all remember those times when we experienced being new to a situation: first day at school, first day on clinical placement, and the first week of taking up a new post in a hospital.

Take a moment to think back to how it actually felt to be a new member of staff.

What are some of the main issues you think your students or trainees might be facing being new to a clinical environment?

What might you as a teacher do to help them?

We will look more closely at how teachers can help in the support of students in the next section which focuses on creating and maintaining an effective learning environment. Support structures need to operate at the level of the individual teacher and also at the organizational level.

**The HEQC's Guidance and Counselling (1994) report highlighted some examples of provision as good practice for the organization including:**

- A whole institutional policy defining the entitlement for guidance and outlining the specific provision and standards
- A systems approach emphasizing organizational structure and clarifying staff roles
- Developing better networks
- Generating better guidance materials
- Providing staff handbooks
- Running a range of staff development activities
- Holding workshops for new staff and students
- Monitoring and evaluating the guidance systems

The GMC explicitly states in *Tomorrow's Doctors* (GMC, 2002) that "medical schools must have robust and fair procedures, including an appeals process, to deal with students who are causing concern on academic or non-academic grounds, such as ill-health or poor conduct. The arrangements for dealing with students and PRHOs must be consistent. This will help to manage the transition from student to PRHO. These procedures will vary depending on each medical school's statutes and individual circumstances. Medical schools themselves will have to determine the most appropriate form of these procedures .....Universities UK and the Council of Heads of Medical School have produced helpful guidance about setting up fitness-to-practice procedures that may be useful for medical schools".

However, in *Implementing the New Doctor* (2002), the GMC noted that "it was not always clear that universities and their NHS partners were working together effectively, or sharing information about PRHO training to improve posts". This problem has been tackled in a number of ways by Medical Schools and the NHS Trusts who take their graduates, for example many Schools now have a formal process whereby they share information about their former students. This will not only include information about the academic status and performance of the student but may also include information relating to other areas which the School feels should be passed on. As can be expected, this has been the subject of much debate particularly where this involves passing on information relating to the health or to the behaviour of the student. There are issues concerned with the Data Protection Act (1998) involved which mean that the data subject (ie. the student/PRHO) has the right to see any information about them which is held or passed on by the School whether or not it was written in confidence.

Clinical teachers are often involved with both students and trainees and can be better placed to observe and give feedback on aspects of performance and behaviour than teachers who have the students in large groups. It is important that clinical teachers make themselves aware of their own obligations and those of the students or trainees and also that they are aware of all the relevant information pertaining to a student or trainee that may be helpful in educating, guiding and supervising that particular individual.

Monitoring and evaluating guidance and support systems in universities was one of the six aspects of provision reviewed in all subjects by the Quality Assurance Agency (QAA) in the round of Subject Reviews. From this section, you might be interested to look at some of the reports in medicine and health professions published by the QAA which include evaluation of Student support and guidance. The reports in medicine for example indicate that in general, support for students is good, although it tends to be more informal (and therefore subject to variation) in the clinical setting. The reports also show that clinical teachers are often unaware of the wider support mechanisms available to students, such as those in the

University and those offered by agencies. Log onto the QAA website to learn more about the current processes of institutional audit and review processes, including access to reports and Codes of Practice for the Assurance of Academic Quality and Standards in Higher Education at <http://www.qaa.ac.uk>

Although there is no one Code relating specifically to student support and guidance, a number of the codes cover relevant areas. The Codes are defined in terms of a set of 'precepts', with accompanying guidance on specific aspects. The most relevant Code to student support and guidance issues relating to clinical teachers are:

## The Code on Placement learning

This Code covers all types of placement, but includes health and safety issues; student responsibilities and rights (including that the student has a responsibility to alert the placement provider and institution to problems that might prevent the progress or satisfactory completion of the course); that institutions should ensure that students are provided with appropriate guidance and support in preparation for, during and after their placements, this includes:

- Appropriate induction to the placement environment including health and safety information
- Any occupational health considerations or requirements
- Any legal or ethical considerations (eg. patient confidentiality)
- The means of recording the achievement of learning outcomes
- Availability of additional skills preparation
- Cultural orientation and work expectations
- Institutional support services that students can access

## The Code on Students with disabilities

This code covers students who have a wide range of impairments including:

- physical and mobility difficulties
- hearing and visual impairments
- specific learning difficulties including dyslexia
- medical conditions and health problems.

Some of these impairments may have little impact on student learning and everyday life, others may affect study or day to day life. Students may enter an institution with a disability others may become disabled or uncover an existing disability only after the programme has started. Some may be disabled temporarily through an accident or illness, others may have a permanent disability.

There is also the Code on Academic student appeals and student complaint on academic matters and the Code on Career education, information and guidance. The Codes provide useful guidance for clinical teachers as well as a checklist for those responsible for organizing clinical placements.

The GMC has also produced a useful booklet *Student health and conduct*, (GMC, 1998), which can be downloaded from the GMC website at <http://www.gmc-uk.org>. The document sets out some of the main issues for doctors who have responsibility for or who come into contact with students. Much of the advice is also relevant to trainees although junior doctors themselves are subject to the GMC's own fitness to practice procedures.



Some key points relevant to clinical teachers are listed in the box below.

- Confidentiality - if doctors think that a student they are treating poses a serious health risk to patients or others, then this information should be passed on to the medical school authorities. If possible the student should consent to disclosure but if they do not, then they should be informed of the action that is to be taken and the reason for it
- Anxiety and stress - medical students are particularly vulnerable to anxiety and stress when learning to deal with chronically or very ill people. This can lead to feelings of being powerless or intimidated in difficult situations. Being under great stress may lead to excessive smoking or drinking, to mental health problems or wanting to leave the medical course. Teachers should be aware of the signs of stress and know the correct mechanisms available to deal with these issues.
- Other issues – clinical teachers should make themselves aware of the medical school's procedures and GMC guidance relating to psychiatric illness, physical illness, communicable diseases, drug and alcohol abuse and behavioural problems or misconduct

Finally, we need to think about some aspects of the legal framework within which higher education institutions operate and, in terms of student support and guidance, these relate mainly to the **duty of care** that HEIs may potentially owe to students.

For more details, see Annex 1, *Definition of a duty of care in a Higher Education environment* which has been taken from *Responding to student mental health issues: 'Duty of care' responsibilities for student services in higher education*, AMOSSHE, 2001.

See also *Ensuring equality of opportunity in teaching and learning* for discussion of some aspects covering equal opportunities legislation and how this might impact on teaching and learning.

If you are interested in reading more about the national picture and how support and guidance is managed in other areas of HE, the HEQC document *Managing Guidance in Higher Education: using quality assurance guidelines: selected case studies* (1997) offers some interesting case studies from a range of subject areas and institutions.

## Creating more effective learning environments for students and trainees

The clinical context is a busy and often stressful environment and the learner/teacher relationship can often be transient or short term. Both students and clinicians complain that the learning environment is often rushed and opportunistic, given that the main focus is to care for patients and deliver good clinical teaching and that clinical sites are often geographically located away from main educational centers, it is unsurprising that the wider support and guidance roles are often not fulfilled as well as they might be.

The SCOPME report *Teaching hospital doctors and dentists to teach* (1994) describes the principles of learner-centred education in postgraduate medical and dental education as follows:

- Education is focussed on the individual needs of the doctor or dentist in specialty training who will learn best when helped to:
  - reflect on and define the problems they encounter
  - acknowledge their strengths and weaknesses
  - decide on a course of action for themselves
  - evaluate their own progress
- consultants need to become learner-centred teachers, mentors and educational facilitators, ie. as well as sharing their expert knowledge and skills, they should:
  - help trainees to develop learning skills
  - provide guidance about what needs to be learned and how this can be achieved
  - help create a constructive and supportive educational environment
- teachers recognise that the skills required to achieve this:
  - are not innate
  - need to be learned
  - can be taught
  - and are essential to make effective appraisals

In all aspects of medical education, the provision of guidance and support by teachers helps students and trainees to take control of their lives and gives them the skills to:

- reflect on their own objectives
- set goals
- adopt appropriate learning strategies
- cope with crises
- review and manage their personal and professional development.

But if learners are to do this it means that teachers themselves have to have the skills and knowledge required to provide effective support.

### Thinking point

Below are some of the activities you might be required to do as a clinical teacher to help and support learners.

Think about some of the practical ways in which you could do this for each activity?

- 1 Identifying learners' educational needs
- 2 Advising learners of the types of support available
- 3 Providing guidance about facilities and learning resources in your organisation
- 4 Following up comments from other staff about students who are performing poorly or whose conduct is unacceptable
- 5 Referring students with particular problems to appropriate individuals or agencies
- 6 Carrying out an appraisal of learners
- 7 Writing a report on learners' progress to the medical school or deanery
- 8 Writing references for former students or trainees

Let us summarise some of the key features of an effective learner support system:

- The needs of individual learners are recognized. Each student/trainee will differ in their levels of motivation and expectation, knowledge, skills and practical experiences, confidence levels and powers of problem solving
- Individuals are prepared for learning to equip them with the necessary skills and strategies and ownership of learning and to help them build self-confidence
- Autonomy in learning is encouraged, while developing the skills of enquiry and critical thinking
- Self-reliance is encouraged – students and trainees should be equipped to access information, advice and guidance as required and guidance systems should support this approach
- The individual is enabled to integrate learning with practice
- Active learner involvement is facilitated with close collaboration and partnership of all those who support the learner
- Difficulties are anticipated and a proactive approach is taken to addressing problems
- Facilities for feedback are provided
- A supportive environment is created in which students and trainees can discuss their learning and openly admit to difficulties and problems
- There is clear identification of roles and responsibilities for information, advice and guidance and clear statements on how each responsibility area will provide the main information, advice and guidance within its remit
- Aspects of advice and guidance are located within the relevant professional area
- Transparent flexible systems are developed which enable both students and staff to access information and support when the need arises, thus encouraging choice and individual responsibility
- Organisational policies and statements are in place which define the rights and responsibilities for learners

Ideally, different elements of the guidance role should be shared by all those who come into contact with students/trainees, including medical staff and members of other health professions, academic staff administrative and managerial staff and other support staff. Guidance can include all or some of the aspects below:

- Academic: embracing subject specific guidance, advice and information on students' overall academic programmes, feedback on assessment, academic development, learning skills and development, recognition and reflection upon learning and key skills profiling
- Professional: including advice and information on performance, continuing professional development, appraisal, careers guidance, recognition and reflection upon learning
- Learning support: including library and IT induction, specialist support for students/trainees with special needs
- Personal support: including welfare issues, financial, health and other personal issues
- Administrative support: including information and advice on all aspects of the administrative system to which students/trainees will relate

### Thinking point

1. Think about the support systems for students, trainees and staff in your place of work.
2. What written materials are available, eg staff handbook?
3. What types of support systems are available and do you know how to access them?
4. Do students/trainees know how to access them?
5. Do you think the support systems are understood by all concerned?
6. Do you think that the support system works effectively?
7. Does the support system match needs?
8. How is careers advice dealt with?
9. How do you ensure that your students/trainees are aware of the support systems in place?

### Setting boundaries and clarifying roles

Many activities facilitate and support the learner and the learning process but they may not be directly related to 'teaching' in the more formal sense. Within medical education the boundaries between educational supervisors, personal tutors and mentors are often blurred. There is a lot of confusion among students, teachers and even institutions about what these various roles entail and often one person fulfils more than one role. Sometimes this is entirely logical and workable but sometimes it is not. Many medical schools have a formal personal tutor system running alongside the academic tutor system. There are conflicting

views about whether one person can or should fulfil the role of a personal and academic tutor for the same group of students and institutions will differ as to the approach they take.

Usually the roles of personal and academic tutor are allocated formally but often tutors slip into these roles unofficially because of relationships that have built up with students. Effective tutors/supervisors are committed to the process and have a real interest in helping students to succeed. Most importantly they have taken steps to understand their role and how that fits in with student support systems. For clinical teaching, this fits with the approach that the SCOPME report *Teaching hospital doctors and dentists to teach* (1994) recommended in its description of 'learner centred education'. "The approach can encompass all aspects of learning, including the acquisition of knowledge and competencies such as practical and 'pastoral' skills that are essential to the development of a good doctor or dentist. All consultants have a part to play; the role of the majority will be to facilitate apprenticeship learning through routine service work. Many will participate in formal teaching ... a smaller number will act as educational supervisors or mentors" (pp.3-5).

## Academic supervision and personal tutors

### Thinking point

Apart from your face-to-face teaching activities, can you list the other roles you play or have played when interacting with students or trainees?

Personal tutors or academic supervisors may have a variety of roles. They may be purely for academic support, to guide the student through a course or curriculum. This may entail acting as a guide, as an advisor or as a supervisor. Most have an administrative or resource-provision role; guiding students to information and resources they may need, again partly advisory. Teachers may also have a professional or career guidance role advising on professional behaviours and attitudes, job opportunities or career pathways. Here we might have to act as a critical friend, or as an advocate or mentor to help the learner identify strengths, weaknesses and self-assessment skills. Whether they are supposed to or not, most will also develop a personal support role. This can be comfortable and beneficial to the student but sometimes puts a tutor in a difficult position. Some basic counselling skills might be needed. Serious personal or professional issues will probably need to be referred onto other support services.

With this wide range of roles an effective personal tutor or supervisor needs a variety of skills and will have done some homework about the programme, the institution and the individual learners for whom he or she is responsible. He or she will know the basics;

- who are the key personnel in the school and how to contact them
- details of the content of the course
- details of the main assessments relating to the learners
- details of support services for referral

He or she will also find out about the tutee, what they have achieved so far, areas they have found difficult and their contact details. Using checklists of professional development plans, portfolios or log-books can help focus the sessions and ensure that areas of need are all addressed. But most of all the teacher needs to know their own capabilities and limitations and also the professional and institutional boundaries within which they are working.

## Thinking point

A number of skills have been identified as important for those involved with providing learner support. Looking at the list of skills in the first column, rate yourself on each indicating whether you feel you are very competent, competent, adequate or not yet competent.

Skill	Very competent	Competent	Adequate	Not yet competent
Listening				
Advising				
Informing				
Assessing				
Counseling				
Advocating				
Tutoring				
Communicating				
Enabling				
Knowing and understanding the mechanisms in place to provide relevant information and the appropriate reporting and feedback channels				

For those where you think you are adequate or not yet competent, think about whether you need to or want to develop these skills and how you might go about this.

We have looked at the multi-faceted role of the personal tutor above so let us look at some of the other formal roles concerned with supporting students into which teachers might be placed.

## Tutor

The academic tutor is seen by the student as being in charge of the learning environment and as a guide to the assessment of learning. Roles include:

- Initiating discussion, proposing new ideas, resuming discussion after a lull
- Giving and asking for information and reactions
- Restating and giving examples
- Confronting and reality-testing
- Clarifying, synthesizing and summarizing
- Timekeeping and holding groups to discussion plan
- Encouraging participation by others
- Encouraging interaction

## Coach or trainer

The coach or trainer's role is often to promote practical skills, where the student or trainee is taken through the steps of learning how to do some action, and skills are developed mainly through practice. It is the role of the coach to notice where the student is going wrong or being ineffective and where intervention would be helpful. The coach can demonstrate good practice and go carefully and slowly through steps where mistakes could easily be made.

## Supervisor

(see section below on educational supervision)

## Facilitator

The word 'facilitator' is used in preference to the word 'teacher' in experiential learning situations where students learn from practical experience, eg in supervised practice in hospitals, as this type of learning requires more facilitation and less direct teaching than learning in the academic environment. Facilitation implies that the activity is one of support rather than initiating. The experience belongs to the student and the facilitator helps the student to get the most out of the experience by providing appropriate resources and intervening in support of the learning. There are different models of facilitation where at one extreme the student is an autonomous learner, in total control of content and process, with the facilitator supporting.

The facilitator role is a difficult one for the 'traditional' teacher in that it involves careful listening and eliciting rather than giving of one's own knowledge. It usually requires that the tutor be student-centred, helping students to express what they understand by respecting them for what they are rather than what they 'should' be.

## Counsellor

There is a difference between counselling and guidance. Teachers sometimes have to adopt a counseling role when students are finding it difficult to find a direction, if they have personal problems affecting learning or to clarify why their learning is not progressing as it should. It is more common however for teachers to adopt a guidance role and often providing comfort, support and a 'friendly ear' is enough.

Guidance usually involves a more directive form of help. With guidance a teacher will probably:

- give information without any attempt at evaluating or pronouncing value judgements on the content
- offer advice based on knowledge and experience
- structure the client's learning experiences by taking positive action in the form of direct intervention

Counselling is a process whereby clients may be provided with help with personal problems that affect their educational progress. The source of the problem that results in a need for counseling may be connected with life outside the workplace. Non-directive counselling provides a setting, a relationship, the conditions and opportunity for a client to discuss with a counsellor the situation that has led to the meeting. Attitudes, thoughts and feelings can be aired in a non-threatening atmosphere; alternative courses of action can be explored, and the consequences of each option can be assessed. In the end it should be the client, not the counselor, who will discover answers and solutions and make decisions as to the course of action to be taken. The counselling role is therefore one of facilitating, by providing an arena and conditions that allow clients to recognize and resolve their problems.

Some of the important basic counselling skills that a teacher may adopt are:

- Icebreaking
- Drawing out
- Listening
- Managing silence
- Clarifying
- Reflecting back
- Questioning
- Summarizing
- Advising
- Target setting
- Prescribing

If teachers have not been trained in the basics of counseling then there are many short courses in basic counseling skills which can be very useful to refresh or learn these skills. However, whenever teachers feel that the situation is becoming difficult to handle, better to draw a close to the discussion and suggest to the student that more specialist help and counseling might be needed. Referral to outside help is also useful in re-clarifying the teacher-student relationship, whilst ensuring that the learner receives the help they need.

In this section, we have looked in detail at some of the roles involved in providing support for learners. Given that blurring of roles and boundaries often happens in clinical teaching, how can the individual teacher manage all the different roles without 'role conflict' occurring? Try the activity below which helps you to think through some of the issues involved in trying to juggle a number of roles, especially if you plan to expand their support role with learners.

### Thinking point

These are some of the questions that might help you decide whether you want to become more involved with students or trainees alongside your current clinical or teaching role

- What are my own likes and dislikes, strengths and weaknesses, competencies and skills.
- Are these compatible with the roles I am playing now?
- Are there any areas that I would like to develop further?
- Do I need to learn any new skills in order to take this on?
- Have I the time to take this on within my current job?
- Is taking on a new role appropriate to my current position?
- Will taking on new roles affect my career prospects either positively or negatively?

If you want to go on to look at some of the practical issues concerned with giving support and guidance to students and trainees, skip the next two sections on educational supervision and mentoring and go onto *Providing practical assistance*



## Educational supervision

There are many types of educational supervision, some of which are purely academic but many of which incorporate academic and/or pastoral tutoring. Supervisors and learners often have a close relationship eg. in supervision for postgraduate degrees where the teacher and learner might spend a lot of time with one another. Other supervisor/learner relationships may be more distant.

The guidance given by the GMC concerning SHOs in *The early years* (1998) which is also relevant to other areas of learning, suggests that learners must:

- “receive educational and clinical supervision which is appropriate to their experience
- never be expected to undertake a task for which they have insufficient experience and expertise
- always have direct access to a senior colleague who can advise them in any clinical situation” (pp. 9/10)

In order to provide effective supervision, supervisors require many of the same skills as the mentor (see next section on *Mentoring*), but while mentors act as personal guides, often working alongside the student, supervisors often have an additional formal role in monitoring progress. Supervision requires clarity about the nature of the learning that is required and supervisors are usually experts carrying responsibility for the work area and for students' progress. This role will probably entail appraising or assessing the learner formally and producing reports on progress. The issue for supervisors is often about when to intervene and when to allow students to learn through discovery. Individuals approach problems in different ways and have different learning styles. Supervisors, therefore, must be sensitive to the way in which the student or trainee is tackling the problem and not impose their own approach inappropriately.

## Educational Supervisors for trainees

Every trainee has a named educational supervisor – a consultant in the specialty or a principal in general practice. Educational supervisors are expected to oversee the education of trainees and to act as their mentors and are responsible for ensuring that trainees are making the necessary clinical and educational progress during the post. The role of educational supervisors is set out in *A Guide to the Management and Quality Assurance of Postgraduate Medical and Dental Education* – also known as *The Green Guide* - published by the Academy of Medical Royal Colleges and COPMed(UK), COGPED and COPDEND (August 2000). *The Green Guide* sets out the key roles of the named educational supervisor, his/her responsibilities at the beginning of a post, throughout a post and at the end of a post. It also sets out the role of all clinical supervisors, including the educational supervisor.

Educational supervisors or consultants are responsible for the assessment and appraisal of specialist registrars and for preparing annual reports for the annual review panel. The GMC's 2002 report on the informal visits to UK Universities from 1998 – 2000 which included reviewing how universities and deaneries had implemented *The New Doctor* noted that most PRHOs said that they received good clinical supervision and guidance. The main concerns were about the lack of support whilst on call, health and safety issues, the standards of accommodation and catering. When it came to educational supervision, most PRHOs confirmed that they received helpful support and guidance from their supervisors, with feedback on performance being particularly helpful (see also the section on *Communicating with learners and giving feedback* below). The introduction of learning agreements which allowed PRHOs and supervisors to discuss and identify learning and training needs, was a particularly positive development. These advances have been taken forward in the Foundation programmes.

Educational supervisors said that greater guidance about their role and responsibilities, together with training, would help them to carry out their role more effectively. Staff development and training and written guidance as offered by some universities was shown to be helpful.

### Thinking point

If you feel that you need more support and guidance, ask your Trust, the linked medical school or the local deanery about written documents and training events.

Appraisal: The process whereby the supervising consultant or educational supervisor provides, through 'constructive and regular dialogue, feedback on performance and assistance in career progression'. Appraisal is a confidential process and not part of assessment. However, the appraisals may be informed by other assessments which are applied throughout the year in preparation for the annual review.

*Tomorrow's Doctors*, the recommendations on undergraduate medical education, when discussing Appraisal, noted that:

"students must receive regular, structured and constructive appraisal from their teachers during the mainly clinical years of the curriculum. This allows the medical school to judge their clinical knowledge and competence against the principles set out in *Good medical practice* (GMC, 1998)

it (appraisal) provides students with information about their progress and performance, allowing them to deal with any areas of concern. This will also help students prepare for the regular appraisal of their performance that will take place once they are qualified" (paras. 67 and 68, p.15, GMC, 2002).

*The New Doctor* (GMC, 1998) suggests that a structured system of appraisal should include:

- an initial meeting with the educational supervisor, or GP course co-ordinator, to consider and develop a personal learning plan
- a confidential exchange of views and opinions about the perceived strengths and weaknesses of the training programme
- opportunities to review and, where necessary, change personal learning plans
- the use of standardized report forms that are signed by the educational supervisor, or GP course organizer and the trainee

The record might take the form of a logbook or personal portfolio. These records are a useful learning tool for trainees, helping them to identify any strengths and weaknesses that may require learning plans to be altered. For some examples of portfolios in medicine, look at the Medicine, Dentistry and Veterinary Science Higher Education Subject Centre site at [www.medev.ac.uk](http://www.medev.ac.uk).

The London Deanery website includes an online training package to learn appraisal skills.

### Annual review:

Specialist registrars are normally reviewed at the end of each year in the grade. Annual reviews are conducted by a specialty-based panel under the aegis of the regional Specialty Training Committee. Educational supervisors or consultants apply assessment methods (see below) throughout the year and the results of these are presented to the annual review panel. The assessment methods and other information brought to the annual reviews are

determined and specified by the Royal Colleges. The annual review panel reviews the evidence before it, taking into account any relevant external factors advanced by the trainee before reaching a conclusion about the trainee's performance for that year.

Assessment: Assessment is the process of measuring progress against defined criteria based on relevant curricula. Trainees have to meet an agreed standard to be able to proceed from year to year and to achieve a CCST (Certificate of Completion of Specialist Training). Assessment procedures should provide both trainers and trainees with a picture, at regular intervals, of the individual's progress. Formal assessment is the process of assessing a trainee formally or informally only for the purposes of giving confidential feedback on performance and deciding what educational interventions are required. This is broadly equivalent to appraisal. Summative assessment is the process of assessing a trainee for the purposes of determining whether a standard has been reached. This is broadly equivalent to the annual review and the end-of-programme assessment.

Being involved in student/trainee assessment is perhaps the most critical of all tasks facing the teacher. When faced with developing an assessment you must be quite clear about its purpose. Typical purposes of assessment may include:

- Judging the mastery of essential skills and knowledge
- Measuring improvement over time
- Ranking students
- Diagnosing student difficulties
- Evaluating the teaching methods
- Evaluating the effectiveness of the course
- Motivating students to study

It must never be forgotten how powerfully assessments affect students and trainees, particularly if it is one on which their future may depend. This influence may be positive (eg. it can drive learning and motivate) or negative and even harmful, eg. in cases where learners are unprepared or who fail. For many learners, passing the examination at the end of a course is their primary motivation. In your role as a clinical teacher you may well be involved with the formal process of assessments but you must also be aware of the assessments in which your students or trainees have to participate so that the support and help you give is appropriate.

## Thinking point

What are some of the ways in which students or trainees might need your support relating to assessment?

Here are some of our ideas about this:

- You can help learners with pre-assessment support. Find out about their assessments, ask them if they feel there are any areas with which you can help them eg. practicing clinical skills for an OSCE, listening while they practice a case presentation, act as a 'critical friend' and offer constructive criticism
- Give students some time to revise for written assessments, offer assistance with planning revision
- Liaise with colleagues to arrange access for them to clinical skills laboratories, to see patients with clinical conditions they haven't had chance to take a history from or to sit in on case conferences
- Find out exactly when the assessments are taking place, be interested in how it went, be supportive but constructive and realistic
- Find out when the results are given out. If the results are good, praise the learner, identify any learning points and then move on....
- If the results are poor, then arrange a session to discuss why things went wrong and make a plan for revision. Look at the learner's strengths and weaknesses and again act as a critical friend. Be willing to act as an advocate for the learner if needed
- If failing this assessment means the learner has to leave the education or training programme, then find out about options. Talk to the learner yourself if you feel you can offer assistance with identifying options for future direction or help the learner to identify the sources of help they need eg. careers advice
- If you feel the learner has become depressed or needs specialist help such as counselling, don't hesitate to step in and arrange this. If appropriate, let more senior staff or tutors know about this. It may be that another member of staff has a closer relationship with the learner and can be of more assistance than you can

For more information on assessment see the *Assessment* resource on this website and also *The Good Assessment Guide: A Practical Guide to Assessment and Appraisal for Higher Specialist Training* published by the Joint Centre for Education in Medicine in 1997.

## Mentoring

The Homeric concept of the mentor is that of a wise counsellor, a good friend, and a role model. The term mentor has traditionally been used in the business sector to describe powerful individuals who take a protégé under their wings with the aim of using their power and influence to shape and advance that person's career. When we use it, we imply something to do with the provision of support and being a suitable role model. Within the field of medical education, the Standing Committee on Postgraduate Medical and Dental Education described a mentor as one who

*'....guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development.'*

The key activities of a mentor can be described as providing academic, personal, and professional support to the mentee. As you can see there may be some difficulty if the same person is providing the mentoring support, is running your appraisals and is in charge of hiring and firing you!

Being involved in a successful mentoring relationship can be enormously fulfilling and can help you to make wise and appropriate decisions about your teaching career. Choosing a mentor is a highly personal thing but a number of issues need to be considered whomever you ask to be your mentor. The most important issue is does the potential mentor have the time and commitment to perform this role? The mentor needs to understand and respect both the purpose and process of mentoring and also to understand the nature and breadth of your teaching and support of learning role. The mentor needs to be a friend, someone with whom one can share failures as well as successes. It is sensible to reach agreement at an early stage about issues around the boundaries of the relationship. Both the mentor and the mentee need to constantly reflect on the remit of the relationship and situations when another person or role is more suitable to deal with an issue. Finally in addition to these classical roles the mentor needs to be accessible in both time and geography and respectful of confidentiality and autonomy.

The type of mentoring relationship described above assumes that the mentee has some say in choosing their mentor. In some schemes a mentor is assigned to a mentee when they join a Department and it is assumed that the relationship will work. In practice, usually the relationships flourish when the mentor and mentee have compatible expectations from the relationship and there is evidence that two elements which contribute to successful mentoring are having mentors who are trained in mentoring skills and where the aims and outcomes of the mentoring process are clearly defined and agreed.

For a more detailed paper on mentoring which describes the process in detail, describes some case studies in higher education and vocational training and lists some useful references, see *Mentoring: Theory and practice*.

For further information on mentoring, role modeling and clinical supervision see *Facilitating professional attitudes and professional development*.

## Providing practical assistance for learners

This section and the next cover some of the specific issues with which you might need to help learners and offers some suggestions as to how you might approach providing support.

In general, it is often helpful for learners if they know that they can discuss a problem (however trivial it may seem) with a teacher. As with any issue, the sooner it is dealt with the better, before it starts to seriously affect learning. On many occasions, it is helpful just to provide general advice and encouragement.

Teachers should:

- Try to imagine what the learner feels like - empathise
- Be realistic about what they can and can't do within their role – recognize limits and boundaries
- Not become too involved or over-identify with the student – be professional
- Remind themselves that they cannot solve everything for the student
- Think about when and to whom they should refer. It is a sign of good practice to refer on when you think someone needs more than you can offer

It can be useful to set aside a specific time (without interruptions) to have a one to one meeting with each of your learners at regular intervals. Sometimes this might be structured around setting up a learning agreement, a progress review or in preparation for an assessment, but teachers should try to devote some time to giving learners an opportunity to talk about their experiences, feelings and any problems or issues they want to raise.

If you are having a one to one meeting with a learner, a framework may be as follows:

- Introduction and purpose of meeting
- Put the learner at their ease
- Explain if you will be taking notes and how any record will be made
- Ask about general experiences and ask how things are going
- Ask about work patterns and study habits – any problems?
- Do they feel prepared for assessment etc.
- Deal with any specific issues the learner wants to raise
- Discuss referral options if needed
- Discuss arrangements for further meetings and follow up

Holding a meeting like the one suggested above in the early days of an attachment or rotation should help to keep on top of most study problems that students or trainees might have and help to develop a good relationship between learner and clinical teacher. Thereafter, many problems might be dealt with as they arise.

## Providing references

Learners may often ask if you can provide a reference for them for employment or placement at another academic institution or hospital. If you think this is appropriate then because this involves the disclosure of personal data in the form of facts and opinions about the person, it is covered by the Data Protection Act 1998. The Act gives data subjects a general right of access to personal data, there are some exemptions from such rights, one of these is in relation to confidential references. However, it is good practice to write a reference bearing in mind that the person about whom you are writing may well see the reference, indeed many referees provide a copy of the reference or a summary of the main points to the person concerned.

References should be factually correct and state the context within which the reference is given. Opinions about a person's suitability should be justified. Statements should not be made which the writer is not qualified to make eg. anecdotal remarks. If asked to express an opinion on an issue about which the writer has limited knowledge, the referee should say so. If you feel that you are not the most appropriate person to give a reference in a particular context then say so.

Any refusal should be communicated with caution so as not to imply a negative reference and thus disclosing personal data.

Where reference forms request information relating to sensitive data e.g. sickness, mental health problems, staff should not provide such data unless specifically requested to do so (in writing) by the data subject. "I am not in a position to comment regarding X's health/sickness record.." would be a suitable response.

Do not submit a brief statement inviting the recipient to telephone you for additional information. Once a verbal reference is committed to a written or electronic record, he/she is obliged to inform the data subject of the existence of this additional information. Do not give an unsolicited reference e.g. for a person who has not, to your knowledge, cited your name as a referee. References should only be given following either confirmation of the identity of both the data subject and the employer, or on specific request of the data subject. Copies of references provided should be kept for a period of up to six months in case of possible litigation from unsuccessful applicants.

## Study problems

If a student is performing well or satisfactorily, it is often enough to congratulate him or her and ask if there are any particular issues that he or she is concerned about. Clinical teachers often have to discuss study problems with learners, you might be alerted to these yourself, these might come to your attention from other teachers or might arise in discussion with the learner. You need to find out where the source of the problem lies.

Typical contributory factors are:

- Difficulty in understanding the material
- Difficulty in memorizing information
- Insufficient time spent studying
- Poor attendance
- Poor organization of study and revision time
- Lack of understanding of what is required
- Emotional or other problems interfering with studying

You might try to help the learner by assisting them to draw up a learning or revision plan, reminding them to be realistic and help them to identify exactly what they need to learn and how they might go about it. Learners need to be reminded that they need to put in the effort and if they have fallen into a 'cycle of failure' then they need to break out of this and raise their performance. They will either have to devote considerably more time to their studies or find a more successful learning strategy.

Remind learners that passing examinations and other assessments is a combination of their **ability** to understand and remember information, the **effort** they put into studying and the **application** of their effort in terms of study and examination technique.

Learners need to:

- Put the time into studying, some people will need less than others and it is sometimes difficult to avoid peer pressure and balance work and leisure time. Remember that if you don't put the effort into studying and fail an assessment then you will only have to resit the assessment.
- Study in defined blocks of about 30 minutes with frequent breaks in which you walk around, get something to eat or drink or make a short phone call
- Take good notes of formal teaching sessions such as lectures and seminars
- Ask questions of staff and make an appointment to discuss specific aspects if they really don't understand. Staff might run a tutorial or seminar on a topic if a number of learners are having difficulty so ask around
- Review the notes after the session and ensure they are accurate and complete, meeting with other learners over coffee is a good way to do this
- Buy themselves one or two good core textbooks that suit their learning style and which they feel comfortable in dipping in and out of
- Check that they understand by trying to reproduce material, by writing lists or drawing diagrams
- Use mnemonics, make them up and get them from friends and books – try to make them fit the topic, the sillier the better!
- Test themselves
- Get enough sleep and have time away from studying every day
- Share their worries with friends or family (or teachers) if they can!
- Act early if they feel they are getting left behind

Exam performance is much improved if learners take an active approach to revising eg:

- do as much practice as possible constructing and answering questions in the form they will be asked or practicing skills
- produce lists of the material they need to learn and use mnemonics and diagrams (eg spider diagrams) to learn the lists
- relate material to concrete and specific examples that they find interesting eg. real clinical cases
- make as many links as possible between the information to be learned
- write down or speak aloud material while learning it or discuss the material with others rather than just reading it or going over it with a highlighter

Problems which are directly unrelated to study might emerge as the 'real' reason that a learner seeks your help. Sometimes it takes time to uncover the problem, but the first step is to identify the problem. As in medicine, this is by a process of history taking and diagnosis and your medical training and experience will be of value here. See the section below on *Communicating with learners and giving feedback* for more information on these aspects.



### Thinking point

Typical problems or issues students might want to discuss which are not associated directly with the course may be concerned with:

- Finance
- Accommodation
- Health
- Personal relationships
- Career advice
- Harassment or bullying
- Illness or death of a family member
- Worries about other learners
- Drug taking, alcohol abuse
- Complaints about other doctors
- 'Fitting in' and cultural issues

For each of these:

- how might you be able to help the learner yourself?
- what additional information might you need?
- which of these might it be more appropriate to refer and in what circumstances?

In the next section, we discuss how you might use University services and external agencies if you are dealing with medical students, and consider other sources of help for those involved with trainees.

## Who supports the teacher? Seeking help and when to refer

In many instances, the clinical teacher is able to deal with supporting and advising students and trainees through a combination of common sense, local knowledge and experience. Sometimes though, in cases where the teacher does not have the specific skills or knowledge or where he or she thinks that the student or trainee needs specific help, referral to other sources of help may be appropriate. Referral should always be with the agreement of the student or trainees unless the learner is at risk to him/herself or to others or where there has been serious professional misconduct.

## Supporting medical students

For clinical teachers who are involved in teaching and supporting medical students, the medical school should be your main source of help and advice. All Universities have central services for students which typically include:

- Occupational health
- Counseling
- Psychotherapists
- Study skills support (including helping with examination issues)
- Senior personal tutors
- Student Union advisors and Nightline listening and practical information services (the SU usually has an officer who deals specifically with welfare issues)
- Chaplains (for all religious groups)
- Disabilities officers
- Equal opportunities officers
- Hall/residence wardens
- International/overseas students' officer
- Registry who can advise on financial aspects, legal issues, accommodation and information on charities that help students
- Central policies and procedures (usually available on the University website) which should include a policy on harassment, an equal opportunities statement, complaints and grievance procedures, etc.

Most medical schools have a personal tutor system which usually allocates a small number of students to a named personal tutor, these personal tutors are overseen by a senior tutor or other senior member of the medical school staff. For example the personal tutor system at St George's Hospital Medical School

“aims to provide students with a reliable point of contact with the School and a source of pastoral and academic support and guidance.

Students can use it:

- To seek help when running into problems of a personal or academic nature
- To seek advice concerning academic matters
- To obtain references for jobs, other courses or to obtain funding (eg. from charitable foundations)
- To raise issues relating to academic or other matters that they wish to make known to the School (in addition to other channels of communication set up for this purpose)

Staff can use it:

- To try to prevent students from falling behind with their work
- To take soundings on issues that relate to the School and the education it provides”

(SGHMS Personal Tutor handbook, 1999/2000)

If students are having personal or health problems, then one of the first sources of help for teachers might be to contact the students’ personal tutor, clinical teachers should discuss this with students and agree how to proceed with tackling the problem.

Teachers should also bear in mind that referral to other sources of information and advice outside the institution (such as agencies or even to other providers of learning opportunities) may be appropriate. Again contact through the personal tutor system should be made as all personal tutors should have access to a list of external referral agencies. In *Student health and conduct* (1998), the GMC notes that it has set up a system whereby medical school deans can be put in touch with other deans who have dealt with issues in particular cases, so there are many networks and sources of help available through the medical schools. Some of the issues identified by medical schools were:

- Stress
- Psychiatric illness (manic depression, psychosis, schizophrenia)
- Eating disorder (anorexia, bulimia)
- Alcohol and drug abuse
- Disability (dyslexia)
- Physical illness (Hepatitis B, Multiple sclerosis, neurological problems, polyarteritis, post-viral illness, uveitis)
- Behavioural problems (indecent, lack of motivation, unprofessional behaviour, violence)
- Accident
- Financial problems
- Gender reassignment

There are outside agencies for the majority of those issues listed above which can offer confidential and free advice and often treatment to students. Contact the medical school, Students Union, health service or the student counseling service for more information. This is often available on the medical school or university website.

## Supporting trainees

For educational supervisors and others with involvement in the supervision and support of trainees, there are a number of useful publications as well as informal and formal support mechanisms provided in NHS Trusts and by the postgraduate Deaneries. *The Green Guide* ([www.copmed.org.uk](http://www.copmed.org.uk)) set out the overall roles and responsibilities of the national bodies and authorities, the key functions of the medical royal colleges in regard to curricula and national standards, and the accountability of postgraduate deans and their teams for NHS aspects of the training process:

- General Medical Council (GMC) <http://www.gmc-uk.org/>
- General Dental Council (GDC) <http://www.gdc-uk.org/>
- Specialist Training Authority (STA)
- Joint Committee on Postgraduate Training for General Practice (JCPTGP)
- Medical Royal Colleges and Faculties
- Royal College of General Practitioners <http://www.rcgp.org.uk/>

- College Committees for Higher Specialist Training
- Postgraduate Deaneries in England <http://www.copmed.org.uk/Deaneries/index.html>
- Deanery Postgraduate General Practice Departments
- Postgraduate Dental Education Departments <http://www.copdend.org.uk/>

## Communicating with learners

Good communication skills lie at the heart of providing effective teaching and learning and learning support and guidance. Poor communication can lead to mistakes, misunderstandings and time-wasting and can have a drastic effect on individual relationships, leading to general feelings of dissatisfaction which can result in poor co-operation. The ability to establish rapport helps provide an atmosphere compatible with effective communication and learning.

Teachers must be sensitive to the views of learners, regardless of their ethnic background, age or gender. It is the teacher's responsibility to provide a secure atmosphere in which consultation may take place. It is very important that teachers acting in a support rather than a formal teaching capacity have good communication skills because situations and topics that arise may require discussion of problems of understanding, and may reveal embarrassment or confusion by students. Simple words which convey the intended meaning should be used whenever possible. In one to one discussions the aim is to convey empathy and understanding and to reassure the student that you are taking what they are saying seriously and are willing to help to solve the problem. The key features of effective communication defined below are relevant to both group and individual situations, involving formal teaching as well as learner support.

### **Key features of effective communication:**

- Establish credibility – it is essential for a teacher to win learners' confidence and approval and that s/he is seen to be reliable and qualified by experience and ability
- Keep lines of communication open through constant feedback
- Establish a rapport with students/trainees and encourage mutual co-operation and support
- Develop a sense of mutual trust and openness
- Correct distortions in communication through constructive feedback
- You must have a clear picture of what you want the other person or people to understand and why
- Try to identify yourself with the psychological state of the other person
- State ideas in the simplest possible terms: define before developing, explain before amplifying
- Develop one idea at a time and take one step at a time
- Use appropriate repetition and review when relevant
- Use analogies
- Use as many channels as necessary for clarity
- Watch for and encourage feedback

**Thinking point**

1. What do you think are some of the significant problems of communication you have encounter during teaching. Consider how you might improve your person-to-person and person-to-group communication and in particular ask yourself whether you are:
2. asking the right questions in the most effective way
3. recognizing and correctly interpreting signals from others
4. listening and using silence effectively
5. talking the students'/trainees' language

## - Giving feedback:

*The New Doctor* (GMC, 1998) notes that feedback from an educational or clinical supervisor is a vital source of information to trainees. Such feedback helps SHOs to identify their strengths and weaknesses which, in turn, allows them to modify their training and practice in order to meet personal and professional goals (p.10).

Here are some helpful tips for giving positive and negative feedback on performance:

- Let the student/trainee speak first: before you give your opinion of good and bad, hear what the trainee thinks: they often have a realistic view.
- Begin with the good points: always find strengths before highlighting the weaknesses. A person who feels good about themselves will be more willing to consider deficiencies.
- Be specific rather than general
- Plan a solution for each problem: never leave the trainee without any idea of what can be done to improve.
- Show interest and involvement: show an interest in helping and solving the problem, rather than scoring points. Coach, counsel and be seen as concerned.
- Be constructive: show that a problem exists. Be descriptive rather than evaluative – describing what we actually see or hear reduces the need of the receiver to react defensively. Involve the other person in defining the problem and encourage them to suggest improvements. Do not expect to find an immediate solution; move 'towards' one.
- Deal with one point at a time: do not collect a catalogue of incidents to be dealt with one at a time. Deal with problems as they arise. Help the trainee to see the possible relationship between one instance and another.
- Criticize the act, not the individual: help the trainee to see the consequences of the actions. Try not to make the person defensive or aggressive, from which position nothing can be achieved.
- Do not hyperbolise: never use words like 'always', 'never', 'too often', etc. Be realistic about the size of the problem.
- Do not joke: never criticize in the form of a joke which cannot be interpreted or can be dismissed.
- Do not compare: never make comparisons with other people. The comparison should be with the person's own potential.
- Be productive: Your criticism should be seen as helpful and as moving the person towards a solution.
- Take into account the receiver's needs as well as your own
- Check that the receiver has understood: if you can, get them to rephrase the feedback to see if it's what you had in mind

Remember – feedback is usually better when invited rather than imposed.

Communication is a two-way process and feedback is probably the best way of getting evidence on the effectiveness of our communication. It enables us to learn about how others see us and about how we affect them.

## Receiving feedback:

- Listen to the person who is giving the feedback, accept what they are saying as genuine and helpful; try to understand their feelings, what they are describing and what they are suggesting you do
- Accept feedback as a gift
- If possible, check the feedback with a third party
- Give the feedback serious consideration, weigh up the consequences of changing or not changing, express your thoughts and feelings about alternatives
- Communicate your decisions to the giver
- Tell them what they could do which might help you to change
- Thank the giver for their concern and help

## Benefits of giving and receiving effective feedback:

- Individuals build up confidence and self-esteem which leads to the ability to master concepts and develop study and cognitive skills
- Those providing guidance develop a range of skills including leadership and communication skills which they are able to apply in other situations. They also gain a deeper understanding of their own subject area.
- Staff get regular feedback on how teaching is being received by the learner.
- Educational institutions and employer organizations are able to provide support and benefit from a more effective learning community and improved retention rates



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Fry H, Ketteridge S and Marshall S. 1999. *A Handbook for Teaching & Learning in Higher Education: Enhancing Academic Practice*. Kogan Page: London.

General Medical Council: The GMC have produced a large number of reports and guidance documents relating to undergraduate and junior doctor training, as well as broader aspects relating to the practise of medicine. The GMC website is at:  
<http://www.gmc-uk.org>

Useful publications referred to in this paper include:

GMC. 1997. *Duties of a doctor*. General Medical Council. London  
(this set of guides includes *Good medical practice*, *Serious communicable diseases*, *Seeking patients' consent: the ethical considerations* and *Confidentiality*)

GMC. 1997. *The New Doctor*. General Medical Council. London

GMC. 1998. *The early years: recommendations on Senior House Officer Training*. General Medical Council. London

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GMC. 2002. *Tomorrow's doctors: recommendations on undergraduate medical education*. General Medical Council. London

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The Higher Education Quality Council produced a number of useful guidance documents relating to all aspects of educational quality before they were superseded by the QAA in 1997. Useful publications referred to in this paper include:

HEQC. 1994. *Guidance and Counselling in Higher Education*. Higher Education Quality Council: London.

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Joint Centre for Education in Medicine. 1997. *The Good Assessment Guide: A Practical Guide to Assessment and Appraisal for Higher Specialist Training*. Joint Centre for Education in Medicine: London.

Note: The Joint Centre was based in London until April 2000 and undertakes large- and small-scale research and development projects in postgraduate and continuing medical education. The Open University, one of the long term partners in the joint centre then took over full responsibility for the Centre which moved to the Open University's main campus in Milton Keynes. See <http://iet.open.ac.uk/oucem/>.

Kinnell, M. (Ed). 1990. *The learning experience of overseas students*. SRHE/UP Press. London

Lago, C. and Shipton, G. 1999. *Personal tutoring in action*. 2<sup>nd</sup> edition. Sheffield University Counselling Service.

Quality Assurance Agency at <http://www.qaa.ac.uk>. The QAA site contains useful documents and reports on general issues concerned with HE. These include the Codes of Practice for the assurance of academic quality and standards in Higher Education; Subject benchmarking guides and Subject Review reports including those on medicine and professions allied to medicine.

SCOPME Report. 1994. *Creating a better learning environment in hospitals: 1 teaching hospital doctors and dentists to teach*. The Standing Committee on Postgraduate Medical and Dental Education.

SCOPME Report. 1998. *Supporting doctors and dentists at work – an enquiry into mentoring*. The Standing Committee on Postgraduate Medical and Dental Education.

Walklin L. 2000. *Teaching and Learning in Further and Adult Education*. (2<sup>nd</sup> ed). Nelson Thornes Ltd: Cheltenham.

Wheeler, S. and Birtle, J. 1993. *A handbook for personal tutors*. SRHE/UO Press. London

The most recent guide to Specialist Registrar training can be found on the Department of Health website at [www.doh.gov.uk](http://www.doh.gov.uk)

The Heads of Universities Counselling Services (a special interest group of the British Association for Counselling and Psychotherapy) also has a website with responses to FAQs and useful links at: <http://www.studentcounselling.org>

## Annex 1

### Definition of Duty of Care in a Higher Education Environment

From: "Responding to student mental health issues: 'Duty of Care' responsibilities for student services in higher education. " AMOSSHE, 2001.

There are a number of areas in which higher education institutions may potentially owe a duty of care to students. The following is a brief outline of these areas and an indication of the implications for HEIs, with particular reference to student mental health. The legal context outlined here refers principally to England and Wales. Some variations under Scottish jurisdiction are highlighted.

#### Breach of contract

It is generally considered that a contract exists between a student and their institution. Students therefore have potential claims if the institution breaches that contract. If an institution refers to certain conditions in its enrolment procedures and documents, it is likely that these, along with some other codes and regulations, would form part of the contract. In addition, there could be expressed or implied duties on an institution relating to the provision of the academic course and the provision of educational support to students.

It is therefore crucial that publicity and other material, for example the prospectus, the Disability Statement, the Student Charter and course handbooks, give an accurate picture of the academic and other support available, and accurately reflect provision at that institution. Students enrolling will normally receive a copy of relevant regulations and codes; students should be made aware that they are 'signing up' to these and are therefore expected to abide by the provisions contained in them. The institution should be aware that it is perhaps more likely to be challenged over the 'implied terms' inherent in the range of materials that could be considered to comprise the contract, rather than those contained within formal regulations: it should vet these other documents just as thoroughly.

Where a student has discussed support needs prior to entry, the precise level of available support should be agreed, if possible in writing. If the student then alleges breach of contract, the explicitness of the agreement will be crucial. If HEIs are unable to carry out this assessment pre- entry, either because the student has not made her/his needs known, or for other reasons, the contract will probably rest on the implied terms only. There is a term implied in all contracts for the provision of services that the supplier will supply the services with reasonable care and skill (Supply of Goods and Services Act 1982, Section 13). Where the institution decides to provide a service such as student support, residential and counselling services, then there is likely to be an implied duty that these should operate with reasonable care and skill.

## Liability for negligence

Students may have potential claims for negligence against an institution if the institution breaches its duty of care. To establish negligence the claimant must establish that:

- the institution owes a duty of care to the student in relation to the subject matter in question; a duty of care would only exist where the parties have a close or proximate relationship (which is often likely to be the case between the institution and student), where the loss caused to the student was reasonably foreseeable by the institution and where it is just and reasonable to impose a duty;
- the institution failed to comply with its duty of care;
- the failure to comply with the duty of care caused quantifiable loss.

Where students are injured on the institution's premises, students can call on the Occupier's Liability Act 1957 (in Scotland: the Occupier's Liability (Scotland) Act 1960). The effect of this legislation is that occupiers of premises owe a duty of care to visitors to the premises to ensure that they are reasonably safe. Therefore the institution owes a duty to take care for the safety of students whilst they are on institution premises. Students could sue the institution if it breaches this duty and the breach causes injury or loss to the student.

The Health and Safety at Work Act (1974) defines the duties of employers, in so far as is reasonably practicable, to ensure the health, safety and welfare at work of their employees. HEIs will normally have a Health and Safety policy based on this Act and on the Management of Health and Safety at Work Regulations (1992). Institutional policies will normally require that all employees shall accept their delegated responsibilities under the Act to ensure a safe working environment. Staff shall have regard to issues of health, safety and general welfare of all people lawfully on the premises, but specifically with regard to each person's area of work and their remit in that area. Students and employees alike may be disciplined for failure to comply with this duty of care, and action can be taken against contractors and visitors who breach the policy.

## Standard of Care

In terms of the standard of care owed to students, the general principle is that the institution has a duty to take 'reasonable care'. In relation to those in any profession or job, the standard expected is said to be the standard of an "ordinary man exercising and professing to have the special skill in question." It is therefore important that institutions ensure that those members of staff, such as tutors, hall managers, wardens, student support personnel, whose work involves 'pastoral' contact with students receive appropriate training to carry out their duties with reasonable care. It is necessary, too, to ensure that all categories of staff are clear as to when and how matters should be referred on to specialist services or agencies, whether or not these are within or outside the institution.

Ideally, this awareness of referral practice should be underpinned by the implementation of clear procedures which assign specific responsibilities for ensuring that students are appropriately supported and referred. These procedures should indicate clearly the limitations of institutional support and highlight where it may be necessary to seek support or intervention from outside agencies and bodies, and the action to be taken.

It should be noted that there may be an enhanced standard of care owed to particular groups of students who may be considered more vulnerable, for example those who are

under the age of 18 years, students who have disabilities and other special needs and international students.

### *Breach of statutory duty*

Students could sue the institution for discrimination under the Sex Discrimination Act (1975) or the Race Relations Act (1976). The Human Rights Act (1998) may bring additional rights for students, which could be enforced against the institution. In particular, the Act gives all individuals rights of freedom of thought, conscience and religion, freedom of expression, freedom of assembly and association, the right to respect for private and family life and to some degree, prohibits most forms of discrimination. The full implications of this new Act are still to be clarified through case law.

A further aspect of statutory duty is in relation to the Disability Discrimination Act (1995) and the Special Educational Needs and Disability Act (2001), which comes into force in 2002. HEIs should take care not to discriminate against students with mental health conditions either in terms of admission to courses or in the provision of education and support services. Clear procedures are therefore required at the point of admission to ensure that appropriate and responsible decisions are made regarding the institution's ability to meet the needs of individual students who identify mental health support requirements. In some cases, professional body entry requirements will impact on these duties.

The Data Protection Act (1998), which came into force on 1 March 2000, strengthens the rights of data subjects in respect of personal data held about them by others. Most HEIs have reviewed, or are reviewing, their student information handling and record keeping practice in light of the changes brought about by this Act. The Joint Information Systems Committee (JISC) has prepared a Code of Practice on the Data Protection Act for the further and higher education communities (See Appendix 3 for reference). The Code covers key issues for the HE and FE sectors in complying with the Act and includes reference to several aspects relevant to the student support context.

## Judicial review

A student may be able to seek judicial review or, in a chartered institution outside Scotland, appeal to the Visitor if the institution fails to follow proper procedures, acts outside its power or acts irrationally or arbitrarily. Examples of this would be if the institution failed to follow its disciplinary procedures in removing a student from the institution or if an examining board failed to follow a proper process in awarding degrees. A judicial review of a decision is not easily obtained, but if granted, may quash decisions taken and require the correct procedure to be followed.

The Quality Assurance Agency's (2000) 'Code of Practice for the Assurance of Academic Quality and Standards in Higher Education: Section 5: Academic Appeals and Student Complaints on Academic Matters' identifies in its precepts the general features that it would expect an HEIs internal complaints and appeals procedures to be able to demonstrate. It is likely that these precepts would be taken into account by a Court in considering applications for judicial review.

An institution's procedures should not arbitrarily be invoked to take inappropriate action against students with mental health difficulties. There is a particular danger, for example, that some students whose mental state causes them to exhibit disturbing behaviour might be inappropriately subject to disciplinary action as a means of exclusion from the institution. HEIs should consider establishing specific protocols or regulatory procedures which encourage or, in extreme cases, require students to suspend their studies if it is clear that their state of physical or mental health is affecting their ability to take full advantage of

educational opportunities, or is causing significant disruption or distress to others. In drawing up such protocols, due care should be exercised to ensure that entitlement to statutory sources of financial support is not undermined.