

A large, teal-colored decorative shape that starts as a wide horizontal bar on the left and tapers to a point on the right, curving downwards.

Mentoring for doctors

**Signposts to current practice for
career grade doctors**

Guidance from the Doctors' Forum

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READER INFORMATION

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 3068
Title	Mentoring for doctors: Signposts to current practice for career grade doctors
Author	Department of Health – Doctors’ Forum
Publication date	September 2004
Target Audience	Doctors, SHA/WDC Workforce Leads. Presidents of Medical Royal Colleges
Circulation List	
Description	This guidance is based on current views about mentoring for doctors and the experience of doctors and managers of schemes that are already in operation. There are considerable variations in how mentoring is perceived and practised. However, despite these differences, the central concepts are consistent – mentoring helps doctors to help themselves, to find their own solutions to indeterminate problems.
Cross Ref	n/a
Superseded Docs	n/a
Action Required	n/a
Timing	n/a
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First published July 2004

Produced by the Department of Health
CHLORINE FREE PAPER

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Improving Working Lives for Doctors

The Doctors' Forum was established in February 2002 after delegates, at the first Improving Working Lives (IWL) for Doctors' Conference, identified the need for a group that could influence policy development in areas that matter most to doctors.

The main function of the Doctors' Forum is to develop and take forward a range of initiatives they deem important to Improving Working Lives for Doctors. Offering staff a better deal in their working lives is essential if the NHS is to retain trained and experienced clinicians.

The Doctors' Forum brings together clinicians, local medical leaders and national representatives to bridge the gap between policy makers and the frontline. Currently, the Doctors' Forum has 80 members including general practitioners, consultants and doctors in training, medical students and medical directors.

In addition to this document for consultation, the Forum has also produced *Welcome to the team*, an introductory pack for junior doctors joining the NHS for the first time, and *Becoming a Consultant*, a collection of frequently asked questions for specialist registrars. Both can be accessed from the Department of Health website www.dh.gov.uk

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Foreword

I am delighted to share with you this guidance on mentoring for doctors. Essentially, this document signposts current practice on mentoring for career grade doctors. This study commissioned by the ¹Doctors' Forum suggests that the benefits of mentoring can be felt by doctors at all stages in their career; medical students to newly appointed consultants.

This guidance provides a flavour of mentoring on offer in the NHS. there are considerable variations in how mentoring is perceived and practised and these are reflected in the case studies and information on the many schemes now available.

I have been fortunate to have received personal and professional mentoring over the years. It allowed me to reflect and learn from my experiences, both good and bad. More than any other developmental tool, it has allowed me to grow as a person and as a professional.

This document can be the springboard for wider discussion within your organisation; healthy community, deaneries and strategic health authorities. I hope that you find these insights on mentoring not only an enjoyable and informative read, but also an opportunity to consider whether you might want to expand your skills to mentoring others.

Professor Aidan Halligan
Deputy Chief Medical Officer

¹ Doctors' Forum brings together clinicians of all grades, and local medical leaders to bridge the gap between policy makers and frontline doctors.

Main findings and recommendations

Findings

Our main findings from this inquiry are as follows:

- The conclusions and recommendations of the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) published in 1998 are still largely valid.
- There is now influential support for mentoring for doctors and many schemes have been started.
- There are many shared understandings about mentoring's main objectives, and principles and values that should underpin it.
- There are just as many differences in terms of the organisational processes that have been adopted.
- The use of the terms 'mentor' and 'mentoring' to cover almost any activity associated with learning assisted by another person is not at all helpful.
- Doctors can benefit from participation in mentoring at almost any stage of their careers.
- The range of benefits includes: general benefits to individuals, help with specific problems and benefit to organisations. They encompass many different circumstances ranging from capitalising on success, taking hold of personal and professional development, taking on new roles and dealing with severe difficulties.
- There is a widespread agreement that mentors benefit from preparation for this role but opinion varies about the extent of this requirement.
- There is little evidence that mentees are prepared for their role, except as part of co-mentoring arrangements.
- Concerns among scheme organisers centre largely on whether to focus mentoring on specific groups; the extent of mentor preparation and support; and outcomes and investment.

Recommendations

Based on the findings from the inquiry commissioned by the Doctors' Forum, we recommend that the benefit from mentorship arrangements for doctors will be enhanced when:

- scheme organisers describe and evaluate their schemes and seek publication of the findings in searchable journals.
- mentoring is promoted as a natural way by which doctors can enhance their careers and deal with difficulties in their performance.
- participation remains entirely voluntary.

- access to mentorship is made as wide as possible.
- doctors can choose the scheme in which they participate.

We further recommend that:

- where a mentoring scheme is restricted to a specific group of doctors, employers and other responsible organisations respond with enthusiasm and appropriate action to requests for a mentor from doctors outside these groups.
- mentoring development programme providers, scheme organisers, authors, and speakers at meetings describe in detail what they are referring to when they use ‘mentor’, ‘mentoring’ and associated terms.
- awareness of mentorship principles and skills is promoted as part of other courses on clinical and educational supervision, management, leadership, appraisal and educator skills development, etc.
- opportunities to develop mentorship skills are included in arrangements for continuing professional development (CPD) and funded accordingly.
- there is a well publicised contact point for information about mentor availability in each trust, postgraduate deanery and medical royal college (preferably a person but also web-based).
- organisations that do not provide their own mentoring arrangements facilitate doctors’ access to appropriate programmes and schemes.

The notion underpinning mentoring is that the mentee is the world expert on themselves, and what one’s there to do is to help them achieve the most from what seems to be available to them. And perhaps to broaden their own idea of what they have the inner resources to achieve. (course tutor)

Developing this guidance

In 2002, the Doctors' Forum, established under the Improving Working Lives (IWL) initiative, identified that mentoring may be a useful support mechanism for doctors if it were more widely available and if there were guidance on good practice.

Since autumn 2002, an inquiry team has:

- Collected information about mentoring schemes for doctors, largely in England;
- Interviewed over 30 career grade doctors and managers;
- Reviewed some of the published literature about mentoring for doctors; and
- Organised two workshops at the IWL conference in October 2003.

The three documents (see list of useful information) produced by the inquiry team have formed the basis for this guidance which was considered by the Doctors' Forum at its meeting on 22 January 2004.

This guidance is therefore based on current views about mentoring for doctors and the experience of doctors and managers of schemes that are already in operation.

The scope of this guidance

Much is now clear about the ways in which doctors benefit from mentoring, but some issues about best how to provide mentoring opportunities are still debated. This guidance aims to reflect the on-going development of thinking about mentoring for doctors.

We aim to give general guidance and encouragement and only specific advice where there is evidence to support it. It's clear that mentoring is not a homogeneous, standard 'product'. There are considerable variations in how mentoring is perceived and practised. This is reflected in the many schemes now available.

But despite these differences, the central concepts are consistent. Mentoring helps doctors to help themselves, to find their own solutions to indeterminate problems – a developmental rather than a remedial approach. But in practice, mentoring is used both to help doctors' self-development and deal with difficulties. Nevertheless, the outcomes for mentees are predominantly developmental, i.e. a change in perspective and understanding which enables them to move on.

Doctors involved in mentoring, as either mentors or mentees, report their experiences very positively. And it's clear that doctors at all stages can benefit. Medical directors who were interviewed value having a mentor as much as do newly appointed consultants.

Organisations that employ or contract with doctors benefit too and ask questions about return on their investment for providing mentoring opportunities. This guidance addresses these issues but experience needs to be evaluated and shared more widely to gain greater understanding and insights.

I'm enjoying working and I think mentoring has allowed me to go forward. It also helped with my relationships within my present practice. It was a fantastic, superb, training ground. I had two days of intensive training and the follow up, I think. The skills that I learned from them I still use. I still go back and read them every now and then and use them in normal practice..... I think it's made me get on with things a bit more, rather than just say 'yes, it's a problem isn't it?' (GP)

How doctors and their organisations benefit

We report separately the benefits that are achieved by mentors, by mentees and by their organisations, but in some ways this is an artificial distinction. Doctors are likely to participate in mentorship in both roles, even if sometimes unknowingly, and the benefits they achieve are so clearly linked to their activities as individual professionals and team members.

Doctors as mentees value primarily the dedicated time for reflection during which someone they trust listens 'actively', challenges their thinking but does not problem solve on their behalf. They work through their problems in a situation of assurance of absolute confidence but within the ethical framework accepted by all doctors.

Doctors as mentees also benefit by being supported and assisted in developing for themselves strategies for dealing with the specific issues that they raise with mentors.

I've found it useful in terms of dealing with relationships with colleagues; that's one of the most stressful things you have to deal with and one of the things that I find tricky. (hospital doctor)

These issues vary widely from checking out ideas for small changes to dealing with dramatic and serious professional and interpersonal relationships.

Many of the strategies they adopt are life changing, i.e. involve the resolution of major crises in professional life, major changes in ways of thinking and acting or significant changes in direction, including the confidence to make such decisions and feel comfortable in doing so. Benefits for mentees who were 'in crisis' also involve regaining self and professional confidence, feelings of self-worth and job satisfaction.

Benefits for mentors include increased motivation and job satisfaction from pursuing and formalising a latent career interest, and recognising that they have helped a colleague. There are significant 'spin-offs' for some into other aspects of their professional and personal lives, including relationships with patients, colleagues and family members. Some mentors, but by no means all, find that the concepts, principles and skills of mentoring provide them with a generic approach to practice which pervades all that they do.

being able to feel that you have helped them and therefore because you've helped them, you're obviously going to help loads of patients, so there's an enormous spin off. Mentoring gives me an enormous buzz which is why I'm delighted to be involved and to share it with other people. It's certainly not something that you do for money, but you do get a lot of professional satisfaction...(hospital doctor)

What the literature tells us

Those who write about mentoring in the UK literature do so with great enthusiasm, suggesting that it has a role not only for the individual doctor but also 'when mentoring is part of an internal, non-hierarchical supportive network, which displays a commitment to facilitating personal and professional development, it has the capacity to transform the professional culture.'

Many government and leading medical organisations now support mentoring for doctors (more details are given in *Mentoring for doctors: enhancing the benefit*). But perhaps the most powerful indicator of the perceived value and current enthusiasm for mentoring comes from the 2002 collation of over 50 schemes and programmes. There was evidence that there were many more; some were established and others had just started. A few schemes had, however, wound down due to lack of support.

I think the one thing that one can say is a priority is that getting people to articulate their anxieties and concerns rather than leaving them to find out the hard way is a very sensible way forward any organisation that hasn't got an environment where people are able to surface those sort of anxieties is taking real risks. (course tutor and NHS trust chair)

Trusts acknowledge that assessing benefits to them as organisations is difficult and imprecise. Some medical managers think that mentoring ought to reduce negative events such as referrals to the General Medical Council and the time the medical director spends dealing with 'difficult' doctors. Other see it as an opportunity to air problems at an early stage, reducing the risk of major and escalating difficulties. Equally managers recognise that indicators such as retention of staff and reduced absence through illness and stress are difficult to relate directly to mentoring, other factors being involved.

Mentoring is, however, seen as a general organisational approach for managing transition points in professional careers. Strong evidence for this can be gleaned from the comments made by doctors who have been mentors and mentees. They identified both general and specific benefits many of which related to their professional work and as members of a clinical team. Generally, they appreciated the value of:

- having someone to go to who makes you feel you were being well listened to;
- being able to address problems and dilemmas in a risk free environment;
- dealing with real problems during mentoring development programmes;
- the action orientation of mentoring – finding ways of addressing real problems; and
- seeing another's point of view and the ability to challenge one-sided views.

More specifically, doctors reported benefits relating to:

- Regained confidence and job satisfaction;
- Improved working relationships;
- Enhanced problem solving;
- Increased sense of collegiality; and
- Making career choices.

More examples are given in the background papers to this guidance.

Mentoring sustained my interest at a time when I was wondering about staying in General Practice and what I was going to do – added a new dimension and new area of interest. It made another interesting side to my work and I feel good about my role as a GP as well as the mentoring work. (GP)

My experience of mentoring

A medical manager

“...in my role as Associate Medical Director, I’ve had to start down the road of a disciplinary with a colleague in trouble – a doctor with problems – who everybody knew about and everybody was talking about.... I spoke to various people about what to do about that because I hadn’t really come across that situation before. I approached a couple of more senior medical directors for their advice with it. Some of it was useful, some of it wasn’t. And again, I made it explicit to them, whether it was the mentoring role or not, I just said ‘This is the problem’. One of them actually knew the person and had dealings with them whenever they worked with their trust. I wanted some help with that. I aired that with [a mentor] a few times and found it useful in terms of clarifying what steps I needed to take that was fair to the person as well as feeling right to me that I was actually dealing with the issues - not avoiding the issues as many people had actually done with this person up until now.

So I suppose I found some of the mentoring I got from more experienced medical directors to be helpful in terms of process, not helpful in other ways. They were giving me their ready-formulated ideas of what needed to be done, which actually wasn’t that helpful, and was wrong – they were jumping to conclusions and trying to get rid of this person. It would have been very, very messy if it had gone down that road. But actually, with the mentoring, being a bit more thoughtful about it, thinking through some of the issues, I was able to get towards what the core issue was with this person which was really about lack of support for her, and being overwhelmed and overburdened and over-stressed... But, once we got those things addressed, it has been quite successful really. She’s functioning very well and everything’s gone very stable and her team has rallied around her. It’s very healthy.”

A general practitioner

“I now believe I make the consultation much more equal for people speaking to each other, rather than me, the doctor, giving the information and, so yes, I think it is doing the course and having a bit of experience, but very limited experience, of another doctor, has influence on my practice. It has given me the confidence to just be me and to try and set up the atmosphere of any consultation I have with a patient much, much more on a one to one basis rather than A talking down to B or the alternative, so I think it has made a difference.

It was something I wanted to do anyway but it’s given me the kind of confidence and, in a sense, in the back of my mind, the technique for doing it, the words that you use, rather than saying ‘you need to do those things’ but instead ‘I think this may be the best thing, how do you feel about that?’ It’s using different bits of ways of talking. I got that from the communication skills but it was also co-tutoring* as well, how to put something over to somebody. You have heard them say something and you want to respond; it’s made you think or feel something and how can you say it in a way that the other person can say ‘Oh, that’s really helpful, yes, thank you’ rather than saying ‘Well, it wasn’t like that at all or no’ so the co-tutoring technique was very useful and I mean that.”

**Co-tutoring (also known as co-mentoring) is a technique that uses mentoring principles but in which two doctors mentor each other on an equal basis, taking turns to be speaker and listener in the same session.*

Changing approaches

There are many opinions of what mentoring is or should be all about. The traditional view is that it is based on a long-lasting, usually spontaneous relationship ‘in which a more skilled or experienced person (the mentor) serves as a role model and supports, guides, advises, teaches, encourages, counsels and befriends a less skilled or experienced person, or a person who is in need of help for the purpose of promoting their professional and/or personal development.’ [1]

The essence of this approach still exists in the many informal relationships that doctors form as they progress through their careers. And indeed it is an approach still much advocated in USA academic medicine, where it is known as ‘faculty mentoring’. Most UK experts advise that care has to be taken to distinguish the roles of mentor from those of supervisor or line manager, and advise that mentors should not be involved in assessments of their mentees.

New models are developed

Now, particularly in the UK, there are other models of mentoring, some of which are based on the flow of help in a single direction – from mentor to mentee – but others in which there is an emphasis on mutual support, described as ‘a dialogue between two autonomous practitioners on a voluntary basis.’ [2]. These are known as co-mentoring or co-tutoring arrangements.

One of the key ingredients in many mentoring and co-mentoring arrangements is the skill of ‘active listening’, a technique that assists those who are speaking, helping them to explore their thoughts and experience at their own pace without interruption and without the listener giving advice. ‘Listeners do not offer solutions, but try to enable those speaking to find their own.’ [3]. Some contributors to the inquiry on which this guidance is based drew a clear distinction between this approach to problem solving and that which doctors commonly apply in a clinical setting, where they are seen as the expert and are required to intervene. Other doctors have told us that applying a ‘mentoring approach’ as described above in some clinical consultations can be very helpful to their patients.

A move to greater formality

The move from informal relationships to formal mentoring arrangements – those that have official recognition of some kind and which may have a defined process – has probably come about in response to a number of factors:

- a decline in opportunities for doctors to meet each other informally and privately;
- concerns that some doctors do not make these informal relationships easily;
- the different culture in general practice where peer supported learning is based on a relationship of parity rather than hierarchy; and
- evidence that some doctors have needs that can be met by a formal mentor at predictable times in their careers e.g. new consultants and GP non-principals.

Two contributors illustrate this last point. In a medical manager's view '.....what we were beginning to recognise was that there were a number of doctors who were approaching us early in their career, having had real difficulties with the transition from being a specialist registrar. The training environment was becoming more and more protective and making that transition into a consultant challenging. As a consequence, many were coming and saying they needed help, usually within the first two years of them being a consultant. It just felt that offering them an experienced individual that they could talk that through with in real time would be better than waiting for the difficulties to arise.' A GP mentor suggested: 'One of the main roles of mentoring within this group [GP non-principals] is that nowadays one has a different approach to CPD and education than in the past. It's taken more seriously; the individual is less passive, more active and portfolio learning and portfolio careers are much more the norm.....The mentor has a lot of different roles - a listener and a support, a tutor or supervisor, someone who can actually help with learning issues.'

Costs and benefits in perspective

But formalisation is not without important consequences. Formal roles require opportunities for role preparation, support in the role, agreed processes for conduct and possibly monitoring of performance and evaluation of effectiveness. None of these is time or cost neutral. But the rewards can be great, even if they are hard to measure. As one contributor, a human resource specialist said 'I can see the value and the benefit from the knock-on effects of the training. I think it actually permeates right throughout your working life; it's not just a case of someone needs mentoring, so therefore you go ahead and do it. The skills that you learn can be used in many different areas of your working life.' A mentoring programme organiser put it this way 'The most commonly described benefit is personal – personal empowerment, personal functionality, personal growth. And that is quite a challenge to quantify, measure and look for. The naïve concept, I think, is that when you've got a mentoring system and formalised relationships, that you will then get an organisation that will benefit, as if the organisation will then function better, that the delivery of care to patients will then be better. I can't see us getting that connection really. However, I do listen to many people say "the way I deal with cross patients is different, the way I manage complaints is different, the way I manage conflict in the department, the way I manage uncertainty, my ability to go and ask when I don't know what the answer is, my confidence."

I really do think it does have a very powerful effect in organisations that's wholly beneficial. I think that the cost as against the benefit, the equation there is enormously positive. For around the £400 or £500 mark per participant I think you have huge gain and hugely accelerated learning, not just for the mentee but for the mentor as well. I think, anyone moving into a new role benefits from the mentoring relationship but, if you were going to put a sort of cost benefit analysis on it, I think the potential payback from mentoring in the Health Service is probably greatest with newly appointed hospital consultants than any other category that I can think of, including chief executives who routinely get given a mentor as they are appointed.

(Course tutor)

Mentorship programmes

KSS deanery scheme for GPs

Mentoring has been taking place in Kent Surrey and Sussex Deanery area since 1994. The scheme began in South Thames West under the educational guidance of Professor Rosslynne Freeman. It was nurtured by Professor Abdol Tavabie and continues to develop thanks to his support. We have defined mentoring as a culture, where peers confidentially enable personal and professional development in protected time. Lynne Freeman in her book (*Mentoring in General Practice*. Oxford, Butterworth-Heinemann, 1998) defines a mentor as 'a senior practitioner, or respected peer, who offers through an ongoing professional relationship with his or her mentee, opportunities to develop, stimulate and maintain their professional development by:

- addressing current professional concerns;
- identifying further learning needs;
- providing space and time to reflect on and evaluate the professional task;
- identifying blocks & hindrances to the professional well being of their mentee; and
- offering help with career appraisal and development.

In KSS Deanery we believe that mentoring should be available for all GPs, though it may be especially valued by a doctor who:

- feels that they have reached a point in their career where an opportunity for thought and reflection concerning their future development would be helpful – the so called 'generic' mentoring;
- is making rapid progress in their career development and has high personal professional expectations and capabilities – the 'high flier';
- has reached an important personal or professional crossroad in their lives where a Mentoring relationship would assist in moving their thinking and personal planning forward; and
- for what ever reason is temporarily under-performing in their role and where a mentoring relationship would be beneficial in helping to restore function and confidence.

KSS has been building a mentor network throughout the deanery, developing mentors in the three-module course for new mentors. We encourage our mentors at an annual conference and maintain them by the support group network, liaison being carried out by our mentor group convenors. They facilitate peer appraisal of our mentors to enable quality control of our network. We currently have around 50 trained mentors and a further 20 in training. We would like to change the culture of GPs to encourage more to become mentees to assist them in maximising their achievements. We believe that the annual GP appraisal process and CPD requirements should encourage more GPs to recognise the value of mentoring.

Contact details:

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More information is available at: www.gpkss.ac.uk/cpd/index.htm

Northern deanery mentoring and professional development programme

Our Deanery programme is now in its 10th year with over 300 participants from backgrounds in medicine and dentistry (primary and secondary care), the academic world, management, nursing, pharmacy, education & midwifery. We aim to create a mentoring culture based on core conditions of respect empathy and genuineness, and offering a balance of support and challenge.

The Programme is based on Egan's 'Skilled Helper' model, and concentrates on first-hand experiential learning, with about half the time devoted to skill development.

Facilitators describe underlying principles and demonstrate the process. Participants practice in small groups with feedback from skilled facilitators and peers. They use their own current issues as material, thus gaining experience of being both a mentor and mentee. To consolidate their learning participants are encouraged to practice outside the programme, ideally with a mentee.

Ethical and professional issues arising from participants' mentoring work are explored. Longer programmes also include an introduction to other developmental tools (e.g. Myers-Briggs Type Indicator) helping people to develop understanding of themselves and others.

The programme aims to:

- develop participants' mentoring skills, and understanding of the process;
- provide a supportive learning climate for personal and professional development; and
- support establishment of mentoring networks within groups and organisations.

Qualitative and quantitative evaluation of learning outcomes include:

- skills development, particularly active listening, non-directive facilitation of change, and problem management techniques;
- using mentoring skills in a variety of situations, including working with colleagues (sometimes co-mentoring) in clinical and managerial contexts, in educational supervision, with patients, and in supporting people in difficulty; and
- greater insight into their strengths and development needs, and a greater understanding of participants' own and other peoples' behavior.

We offer half or one-day tasters and four or five day programmes, and have experience of working with deaneries, royal colleges, trusts and specialist groups.

Contact details:

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Julia Pakora Tel: 01609 770 874 E-mail: julia.pakora@coachingforchange.co.uk

Health Partnerships 'Masterclass in Mentoring for NHS consultants and general practitioners'

The 'Masterclass in Mentoring' is an intensive one and a half day course in mentoring skills. It is endorsed by Professor Sir Ian Kennedy, is accredited for continuing professional development and has been held at 15 trusts.

The Masterclass is designed for a class of ten to fourteen consultants or GPs and is led by two facilitators experienced in working at board level in the NHS and in the private sector. The role of the mentor is defined, the skills of effective mentoring are practised and case studies illustrate difficult situations and ethical issues.

Setting up a mentoring programme

In addition to the training of the mentors we offer advice to the trust on how to set up and run a mentoring programme for doctors, how to brief the mentees and match them with the mentors. We also advise on the need for continuing support for the mentors and we carry out an evaluation of progress.

Aims of the mentoring programme

The initial aim of most trusts we have worked with has been to provide a skilled mentor to every new consultant or GP as a source of knowledge, support and advice to help them become effective in the new job as quickly as possible and to encourage them in their professional development. Mentors may then be offered to established consultants or GPs who are in difficulty and the longer term aim is for every doctor to have a mentor.

Health Partnerships

The Principal of Health Partnerships is Sonia Hornby, a former NHS Trust chairman, Honorary Degree of Doctor of Science, University of Birmingham. Members of the advisory board include Professor Sir Ian Kennedy, Chairman of CHAI, and Dr Michael Durkin, Director of Clinical Performance at Avon, Gloucestershire and Wiltshire SHA, who piloted the Masterclass.

Contact details:

For further information we can be contacted at:
Badgers Farm, Idlicote, Warwickshire, CV36 5DR
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Cygnus mentoring and professional development

This company was founded by former GP, Dr Peter Harborow, who, over the past 14 years, has had extensive experience of mentoring with doctors, within both primary and secondary care sectors. Our approach is holistic, taking into account the individual needs within the organisation. We have specialised in mentoring, believing that the integration of both personal and professional life is important to wellbeing in a medical career.

We offer sessions of individual mentoring, help with setting up schemes, training and learning sets for mentors, facilitation of support groups with theoretical input and courses on communication and mentoring skills for those involved in medical education. We have devised a mentoring programme, that is awaiting approval for academic validation by the Open College Network and which will be applicable throughout the UK. A national conference on 'Mentoring in Medicine' was held in April 2004 and Cygnus are in the process of setting up a national network of mentors and mentor schemes in the UK.

Contact details:

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MiAD UK

MiAD is a training and development organisation working specifically with doctors in the NHS. The company has worked in partnership with the NHS providing management and development training for thousands of doctors in many hospital trusts, PCTs, deaneries and other related health organisations.

In addition to some developmental work with medical directors, MiAD currently runs two programmes that deal with the topic of mentoring for doctors. The first is designed for trusts that are considering setting up a mentoring scheme for consultants. In addition to considering the skills a mentor may need the programme also deals with the organisational issues involved in running and evaluating a mentoring scheme.

The second programme looks at mentoring for trainees and specifically focuses on the role of the educational supervisor. This programme helps educators consider the mentoring role, how mentoring can benefit trainees, trainers and the organisation and how to deal with situations that are challenging and/or difficult.

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The Education Support Unit Mentoring programme

The Education Support Unit (ESU) Mentoring Programme is an NHS based consultancy focusing on the development of mentoring programmes within the NHS.

The unit has particular expertise in developing mentoring for GPs and new consultants.

The unit offers:

- Mentor programme management; the overall design and ongoing management of mentoring programmes for PCTS and trusts;
- Training programmes and learning sets for mentor development;
- Conferences; and
- Consultancy on the development of mentoring for doctors and other health care professionals.

Current mentoring programmes include:

- GP Non-principals in North West London;
- New Consultant programmes in six acute sector trusts in London; and
- Inter-professional programmes for GPs and nurses in PCTs.

The ESU Mentoring programme is led by Professor Patrick Pietroni, former Dean of Postgraduate General Practice in North West London.

Contact details:

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Co-tutoring in general practice

Co-tutoring is a form of co-mentoring where both parties are both mentor and mentee and act as speaker and listener in each session. Co-tutors need some training to be able to use the method with confidence. The scheme is administered by the East Anglia Faculty of the Royal College of General Practitioners but we can run training courses in other parts of the country.

Contact details:

For further details please see the website www.co-tutoring.org

Moving forward with mentorship

Dr Nancy Redfern, Professor Jenny Simpson and Mr Eric Waters met at the Doctors' Forum to discuss the present state of mentorship for doctors and how it might develop.



Nancy Redfern is a consultant anaesthetist and associate postgraduate dean in the Northern deanery. She has led the mentoring development programme there for the last eight years.

Nancy Redfern: I thought it might be helpful to reflect on 'Where are we now?' in the Northern Deanery, having had eight years of formal mentor development programmes. We've had quite a large throughput, over 300 doctors and dentists - GPs, managers, university academics, pharmacists, podiatrists - just people who've done the programme. So we've established a programme that works and an ethos that mentoring is a good thing that has permeated into trusts, specialties and other groups. Within a trust or a specialty group you have to have somebody who's going to champion mentoring to start a move forward. People who've done the mentoring programme and who've used the mentoring skills have achieved an enormous amount in terms of personal growth. This stems from learning the skill set of mentoring but also from using mentoring for themselves and for others. They are now at a point where I think we see more of them in key positions – they are our influencers and our developers.



Jenny Simpson OBE is Chief Executive of the British Association for Medical Managers (BAMM) and is a member of the NHS Modernisation Board.

Jenny Simpson: Elsewhere I would say that progress has been patchy. Your pioneering work isn't being made available yet all over the country. There are also different levels of looking at this. One is the skills of mentoring and the positive, practical benefits that arise and the other is the philosophy of taking some time out to think about what you do and how you do it and to help somebody else along the way. There are different ways of doing that last bit and mentoring is one of them. Either way, I think it is a hugely important thing to do. The process of being a mentor to somebody else has as many benefits to the individual which, you know, are certainly equal and as long lasting as they are to the person who is being mentored.

Nancy Redfern: I would say 'it's a learning relationship.'

Jenny Simpson: It is a relationship and I think it should be seen as that, particularly when you're trying to justify it. But there are still people in a number of parts of the country who will say 'Yes, you should do it but no you can't have the time and, by the way, that person's far too far away and there's no way you can have them as a mentor' and so on. At BAMM we certainly try to help people with mentorship in the management side of their work but, again, often only lip service is paid towards it. Putting mentoring in place can be quite challenging. So there's a mind shift that has to take place.

Nancy Redfern: We did have that problem and people will make similar comments ‘under the table’ ; that’s still a problem. But it’s now got to a point where if a mentor is present they’ll say ‘I’d just like to challenge your perception of that’ and so it’s becomes much easier for the mentoring word to spread.

Jenny Simpson: What’s also changing is a number of very influential people, medical directors or clinical directors or presidents of royal colleges are now referring to their mentor in public – ‘I have a mentor and it has helped me’ and having champions of the cause nationally is something new.



Eric Waters is a retired consultant in A&E medicine and former medical director and director of clinical effectiveness at Salisbury Health Care NHS Trust. He was appointed as the Improving Working Lives Doctors’ Champion in 2003.

Eric Waters: In our trust I perceived the real need for new consultants to have a mentor. What we’re talking about is supporting doctors in some shape or form and it seems to me that people have a problem with definitions. Is support the equivalent of mentorship or is mentorship part of support? Where does coaching fit in? Where does advice fit in? Who provides it and how do you do it? If you think about counselling for medical students and PRHOs and about providing them with help with their career choices, this may not be mentoring but it’s actually about support again, isn’t it? People do talk about mentoring as being different things. Some people talk about it as being coaching which is not how I see it.

Jenny Simpson: At BAMM we do both. We try and help people find mentors and we provide coaching.

Nancy Redfern: One of the key messages that feels absolutely right and important in the Department’s guidance is that mentoring is perceived by different people as different things and we’re not trying to make it one thing. It’s very important that we describe what we’re talking about. We’re saying ‘What I’m talking about here is helping people to become better at helping themselves, helping them develop their opportunities and manage their problems, helping them become more effective, more functional, more empowered members of the workforce.

Eric Waters: Yes, you need to define that so that no-one is under this misapprehension that it’s actually about somebody else telling you how to do it.

Nancy Redfern: The skill set you develop by learning the core skills of mentoring can be involved every time you help somebody. You actually use them when you are advising and when you’re coaching, as well as when you act as a sounding board or challenging friend. If someone says that they want advice, in fact your solution to their problem isn’t usually of much help. What you need to do is give them their solution to their problem. And doing this involves active listening, empathic challenging, exploring possibilities, just the same as in mentoring.

It’s the terminology used within medicine that’s the problem - what’s the acceptable way of saying ‘I need something because I don’t know the answer to this?’ Diagnosis is largely puzzle-solving; there is a right answer. Working relationships and being functional and effective within an organisation is about managing problems, not puzzles. The skills you need to problem solve are different. We don’t teach these skills to medical students or doctors.

Jenny Simpson: You have to re-learn how you work with others and how you build working relationships. I certainly had to. Many of the skills that you acquire in learning to be a mentor or a coach are about managing different sets of probabilities and managing different sorts of uncertainty in relationships.

Nancy Redfern: ...and expressing uncertainty and working with that and complex systems. Often the problem is not solvable so the only thing you can do is work with a team to come to a joint way of managing. In contrast, as a doctor, you're told your role is to take responsibility and to take action.

Is mentoring for everyone?

Eric Waters: Clearly, I perceived in our trust that new consultants were a group who were entering into a very, very different environment. Some of them realised it, some of them didn't.

Jenny Simpson: It's the ones that didn't that you're most concerned about. I would say new consultants, in my experience, are thrilled to be appointed as a consultant. They are thrilled for about four weeks into the job and, from there on in for about two years, go into a decline and depression because they find they don't have the skills of being a consultant which is as much about working with and through others as it is about direct clinical work.

Nancy Redfern: I think it should be accessible and available but not imposed. People use mentoring at times of change. We have a mentoring scheme for our newly appointed consultants and some of them take off and have a brilliant skill set and do really well. One of the mentees we've had in our programme has just, at a very young age, become a clinical tutor with buckets of skills. But I don't think I can look at people and make a decision about the stage at which their need will arise. It may be a month into the job or it may be two or three years down the line when your enthusiasm to change something hasn't worked. It may be after four or ten years when you think 'Well actually, I think I can do the day job so what am I going to contribute that's interesting and different to the Health Service?' It may be coming towards retirement. I can't spot it.

Jenny Simpson: I think it's different for different people.

Eric Waters: I think you're right. The reason I work with new consultants is not because I perceive others do not need it but it seemed to me that they are an obvious group that floundered, as it were. But there again, I teach on management courses for specialist registrars and I'm struck, for example, how few of them actually recognise what they actually want out of life. They take a job on because Salisbury's a nice place or because the wife wanted to go there or whatever it might be.

Jenny Simpson: There's the issue about career coaches as well. The whole prospect is so bewildering but if we had career coaches at PRHO level or SHO level to SpR level and actually help people make career changes, we might get somewhere.

Eric Waters: Often a young trainee will go into a role because their experience of the people they work with was good. That may not be a good enough reason.

Jenny Simpson: The medical career process is not managed at all.

Nancy Redfern: We've done some work on this in two-hour sessions for medical students in their first year and then following it through in their second year of learning helping them to listen to each other - Stage I of Egan's model. It's about helping somebody else think through a concern. The students are very good at it. But I hear from my personal tutees that it does not feel right with the rest of the sausage machine of going through medical school.

The future for mentoring?

Jenny Simpson: There's a danger if we just leave it to grow organically that it will do precisely what it is doing now which is growing where it can and not where it's may be more needed.

Eric Waters: That's absolutely true isn't it?

Jenny Simpson: Therefore, the only way that it will become more established and much more accepted would be through a national framework.

Nancy Redfern: One important next step is to publicise the findings, to encourage people to take the first step in using and developing mentoring. Although people recognise that it's a good thing, they need to ask whether that means we should have it in our college, in our trust or amongst our specialist group. I started by thinking we need to support people in starting schemes, both mentors and mentees. But what I probably mean is that we need to mentor people who are trying to start schemes, facilitating, networking, talking about what we have been doing, so others can choose from a menu of what's available. That's going to enthuse and encourage people, so they start to want to be mentors and to use mentorship. I'd just love to get to a point where doctors are told 'We really value you, so we're going to give you a mentor' and doctors say 'Oh, good!' rather than as now 'Oh, blimey; I need a mentor. I can't be doing well'.

Eric Waters: Bearing in mind what we have discussed about careers advice and counselling, is mentoring the central point for networking the careers advice and the counselling or the guidance? The second question is how does it fit in with appraisal? Is there any linkage?

Nancy Redfern: We realised that mentors have a skill set and so we offered to do the appraisal training for the appraisers. Some people use the mentoring scheme to get their ducks in order before they go for the appraisal because they can see 'robust process' written on this. Some use it afterwards, the appraisal having brought out an issue where there's a development opportunity for their career that they had not spotted or 'We're aiming at a brick wall with this little issue. What are we going to do to get round that?' So I can see it as a supportive process both before and after appraisal. I can see the skill set of the mentors helping to ensure that the appraisal discussion has the right balance between support and challenge.

In summary?

Eric Waters: Every doctor should have access to mentoring. This probably is as broad a statement as I can make. You can't make people do it but what you can do is offer it.

Jenny Simpson: As many doctors as possible should acquire the skills of mentoring and as many doctors as need it should have access to it. It should be nationally available and be recognised as a good, strong, supportive way of helping doctors do their jobs.

Eric Waters: And the NHS should welcome it because it'll be helping doctors who will be better doctors.

Nancy Redfern: Mentoring has something really important to offer. It helps us achieve our full potential, develop the services we offer and the organisations in which we work. Doctors should have mentoring available and the opportunity to learn the skills involved.

Getting started with mentoring: issues for exploration

The evidence is clear that mentoring brings enormous benefits to some doctors. But before setting up a scheme or deciding to participate in one, it's probably helpful to look at some of the issues which are still being debated. Knowing that there are uncertainties about the mentoring process and exploring them with colleagues locally or on mentorship development programmes may make participation much more rewarding.

- **Who will benefit from mentoring?**
- **Why don't all doctors want a mentor?**
- **How can barriers to participation be overcome?**
- **How do mentors best prepare for and develop their role?**
- **Do mentors need support in their role?**
- **How formal should the role of mentors be?**
- **Should every organisation have a scheme?**

There is strong evidence that doctors may benefit from mentoring at different times in their lives and careers. In this section we explore some of the current uncertainties – not to deter participation – but to encourage reflection and sharing of experiences and to promote sound development. The UK literature is still limited and **we recommend that:**

- scheme organisers describe and evaluate their schemes and seek publication of the findings in searchable journals.

Who will benefit from mentoring?

Traditionally, a period of transition, such as when taking on a new role, is the time when many will seek a mentor but there are many other situations that cause doctors to look for additional support. To make the best use of resources some organisations have set up schemes to help specific groups. This 'targeting' approach may assist schemes by:

- making it easier to estimate the size of the task ahead;
- ensuring enough mentors are prepared;
- making the necessary business case;
- helping to raise the necessary funding; and
- making monitoring, evaluation and development easier.

But there are problems with targeting. Mentoring may not be the most (cost)-effective tool in some circumstances. If, for example, there are enough doctors in a particular group, say new consultants, who have enough needs in common then some kind of formal educational programme may be more appropriate and make it easier to ensure quality and availability. Mentoring also relies very heavily on one-to-one interactions. Not everyone may find this a comfortable experience, particularly where there has been no time and experience of each other to allow trust to be built up naturally. There may be a shortage of suitable people with enough time to be mentors. If the role of the mentor is cast very widely, serious questions have to be asked as to whether it is reasonable to expect one mentor to be skilled in all these areas. Having one 'official' mentor may limit the benefit to that which one person can provide.

It is also a mistake to see mentoring as a cure-all as one US author puts it: 'Mentoring is not a technique that can be applied like a warm blanket to solve the problems of orientation, training, skills development and retention. There are two reasons why mentoring isn't foolproof – the mentor and the protégé.' Moreover, some people within medicine still seem to believe that requesting or offering additional help implies a weakness or lack of readiness for a new role, rather than a valuable opportunity to gain extra skills, knowledge and insights to allow the person helped to achieve even greater success.

Further targeting mentoring at, say, new consultants may make it harder for established doctors to recognise this need for themselves and request support either when they take on new roles or when they are facing difficulties in their professional and personal lives. Providing a mentor for doctors in an identifiable group, where the mentors are not themselves part of that group, could exclude the strength of peers sharing experience and support and developing peer networks.

In its 1998 report SCOPME pointed to the need for mentoring to be part of an overall framework of support and concluded that: 'any initiatives to bring in more formal systems of support, such as mentoring, should complement informal support and not seek to replace it.' This advice is still valid. There could be a possibility that providing arrangements for doctors to be mentored might almost be an easier option than tackling wider and deeper cultural issues, and institutional and professional pressures that make them necessary in the first place. This would impose an unreasonable expectation on the mentoring process.

So although targeting schemes has considerable operational value, we would hope that it is only the first stage in making mentorship for doctors universally available. It is probable that more doctors might be drawn to formal arrangements if they had a choice of schemes, such as in their own trust, in another trust based, deanery based, or royal college based, etc., each with its own ethos and requirements.

In the absence of clear evidence about exactly which doctors will benefit from mentoring, **we recommend that:**

- mentoring is promoted as a natural way by which doctors can enhance their careers;
- participation remains entirely voluntary;
- access to mentorship is made as wide as possible;
- doctors can choose the scheme in which they participate; and
- where a mentoring scheme is restricted to a specific group of doctors, employers and other responsible organisations respond with enthusiasm and appropriate action to requests for a mentor from doctors outside these groups.

Why don't all doctors want a mentor?

All doctors have been influenced during their careers by other people in ways similar to those described as informal mentoring. The 'mentors' may not be consciously identified as such at the time, if ever. It is possible therefore that the support needs of doctors who do not request a mentor as part of a formal scheme may be fully met in other ways. There is some evidence that highly successful doctors are also good at finding informal mentors and therefore may not require to participate in formal schemes – they have their own well-developed mentor seeking skills. It would be useful if these skills could be characterised in more detail and learned.

How can barriers to participation be overcome?

Apart from having other support mechanisms in place, there are other reasons why doctors may not choose to have a formal mentor. There may be a number of barriers, including:

- ignorance of what mentoring is all about;
- multiple interpretations of what mentoring may entail;
- a suspicion that it is a managerial process;
- a lack of willingness to trust another, maybe unknown, person with personal issues that might imply professional failures;
- a lack of perceived need as there are no obvious current problems to be solved; and
- a lack of suitable mentors.

Some argue strongly that agreeing a clear, single definition of mentoring would be helpful. Although using the term loosely to describe any learning process helped by another person is counterproductive, the many ways that the term is used also reflects the many contexts and needs that are driving its increasing popularity. So instead of trying to impose one definition, **we recommend that:**

- mentoring development programme providers and scheme organisers, authors, and speakers at meetings, describe in detail what they are referring to when they use 'mentor', 'mentoring' and associated terms; and
- awareness of the range of mentorship principles and skills is included in courses on clinical and educational supervision, management, leadership, appraisal and educator skills development, etc.

Some of the barriers will be overcome as formal mentoring becomes more widely understood and accepted but strategies to 'introduce' doctors to mentoring seem to be very worthwhile. Contributors have reported a number of ways of doing this and they are listed in the Box below. We would urge that scheme organisers' enthusiasm to obtain a high uptake needs to be tempered by the need to avoid any sense of coercion. Further, a doctor having a mentor only 'on paper' and never meeting is unlikely to be useful.

Contributors who advocate allocation of mentors have emphasised that mentees 'can always ask for a different mentor' (less commonly vice-versa). However, it is unclear what level of confidence mentees need to do this, given the concerns that many have about entering the relationship in the first place. The possibility of causing offence to the mentor and fear of repercussions may be powerful deterrents to changing mentor.

Introducing doctors to mentorship

- provide written information about a scheme
- publish lists with or without personal details and photographs of available mentors
- the medical director or scheme administrator extends a personal invitation to doctors to take part
- a mentor makes contact with a particular doctor, explains and, importantly, demonstrates what is involved and offers to be that doctor's mentor
- a mentor is allocated to a doctor by a scheme administrator and the mentee is expected to arrange the first meeting
- a mentor is allocated to a doctor by a scheme administrator and the mentor is expected to contact the mentee to arrange the first meeting.

A somewhat different approach involves 'taster' events being organised that provide insight and experience of the principles and practice of mentorship without any prior commitment to participation in a mentoring relationship. Such an introduction could be incorporated, for example, into new consultant programmes or Royal College educational events. If established consultants, who will be the mentors, participate in these taster events and demonstrate appropriate mentorship skills and attitudes, some of the mentees' concerns around trust and choice of mentor may be addressed. It may be helpful to provide prospective mentees with opportunities to share with each other any concerns about mentoring relationships in private, peer-group discussions allowing them to draw on their collective experience to resolve some of the issues that would otherwise be taken to the mentors. This would be a form of mentee preparation which is notably lacking at the present time.

We therefore recommend that:

- opportunities to learn about mentorship are included in arrangements for continuing professional development (CPD) and funded accordingly.

Despite best efforts to encourage doctors to participate there will be some, possibly many, who will not – or at least, not until they are ready to do so. Although it has been said that doctors who do not accept a mentor are those who may run into difficulties, we consider that their decision should be respected and their needs met through informal support, appraisal and professional development planning.

How do mentors best prepare for and develop their role?

There is no doubt that doctors wanting to become formal mentors in a organised scheme will benefit from preparation for the role. But this raises a number of questions that are listed in the Box. This inquiry did not specifically seek answers to these questions but perhaps some suggestions may be helpful. Intuitively, it is probable that the more in-depth the preparation the more likely it is that mentors will acquire the necessary skills, become confident in the role, sustain and practise what they have learned and be aware of the limits of their competence and responsibility. Some might well argue, however, that doctors who offer themselves as potential mentors are likely to be the people who have an interest and aptitude for this kind of work and be likely to have a good foundation of appropriate skills which just need re-alignment to the principles of mentoring and 'topping up.'

Questions about mentor preparation

- how much preparation is needed?
- what should it comprise?
- how long should it last?
- who is in the best position to provide it?
- how do we choose a programme and a provider?
- what should it cost?
- do we need to continue to support mentors in their role, and, if so, how?

Contributors to this inquiry have, however, said that not all the skills needed for mentorship are intrinsically part of medical practice. Indeed the skills of active listening and challenging without intervening with good advice are almost the antithesis of some aspects of clinical work where the doctor is 'the expert', expected to 'know what's best' and intervene promptly with outcomes that are often judged mainly in the doctor's terms. As one contributor remarked 'You have to learn to sit on your hands'. Contributors have also told us that it is hard to stick to the requirements of the formal mentorship interaction in the midst of the hurly burly of daily practice 'You need to remind yourself to get your brain into the mentor mode' as one contributor said. It is possible that the contrast between mentorship and clinical practice may be sharper in some specialties than others.

It is also the case that the practice of mentorship by doctors is not uniform. Some arrangements encourage interactions that are fairly free and easy, albeit within ethical boundaries. The mentor and mentee may meet over a meal or in the pub, the mentor may take the lead in reviewing the mentee's progress and knowledge of local 'politics' and networks, and legitimately provides information and advice based on his or her own experience. Both parties may take action based on the discussions and notes may be kept to facilitate follow-up at the next meeting. Other schemes require much more formalised interactions that stick to a planned process where the mentee (or speaker in a co-mentoring arrangement) initiates the discussion and the role of the mentor is purely to facilitate the mentee's exploration and conclusions through challenge and reflecting back what is being said. Notes are not kept and no reference is made to the content of the interaction on a subsequent occasion unless the mentee/speaker raises it again. The mentor/listener only responds to the speaker/mentee's issues.

So the most appropriate form of mentor preparation and, we would advocate, mentee preparation, should depend very much on what schemes expect of the participants, their relationships and the interactions that give expression to them. These expectations should be made as explicit as possible.

Do mentors need support in their role?

Mentors will draw on their own past experience and skills learned in other roles. But we would not expect doctors to be adequately prepared by a single educational event for the very diverse issues that they may come across and the variety of mentees who may ask for their help as mentors. At least in the early phase, perhaps lasting many months, we would expect mentors to benefit from on-going opportunities to reflect on their role, share experiences in confidence and refresh their skills with mentor peers and facilitators. Further, less experienced mentors can benefit considerably from learning from their more experienced colleagues.

We do not sign up to the view that if mentors do not ask for further advice and support, that they do not want or need it. Scheme organisers too have an on-going responsibility to ensure that all is well. Mentor development and support events are a useful way to do this.

Questions about the formalisation of the role of mentor

- Do we need to select and 'appoint' mentors?
- Should there be agreed aptitudes and skills/competencies and responsibilities?
- Is it helpful to formalise these into a person specification and 'job' description?
- Should there be accepted standards of behaviour and 'performance' in the role?
- How will these be assessed and monitored and by whom?
- Should the role of being a mentor be officially recognised and, if so, how?

How formal should a mentor's role be?

As an extension to these issues colleagues are also discussing the professionalisation of the role of the mentor. Some of the questions being asked are listed in the Box.

Many doctors who have put themselves forward for formal mentor development programmes have self-selected and many seem automatically to become available as mentors. Programme organisers have told us that they 'reserve the right' to recommend that doctors who have completed a programme do not then become mentors if they feel that they are completely out of sympathy with the principles and practice of mentorship. But this happens rarely. Medical directors can exert some control over who is put forward as a mentor in Trust-based schemes and in schemes where mentors are allocated this control can be much more easily exercised.

An outcome of increased formalisation could be a clearer definition of the characteristics and objectives of any particular mentorship scheme. But the practice of mentorship cannot be guaranteed to comply with a 'job description' unless there is some form of monitoring, assessment and/or supervision.

We have little information about whether doctors as mentors need supervision, and, if so, how this might be achieved given the scarcity of funding and time and the intrinsically confidential nature of the interactions with, commonly, a lack of any formal output. Schemes that require or encourage participants to re-convene for support and rehearsal of skills that is mediated by a facilitator could be said to offer a very indirect form of supervision.

The issue of remunerating mentors, either directly in the form of a fee/locum expenses or indirectly through allocated time within a job plan, needs to be considered too. Payment of this kind implies an agreement to carry out a task or role professionally and accountability for performance to a given standard. Not having any way of monitoring that performance does not seem to be consistent with remunerating mentors. We have very little evidence, however, that the performance of mentors is monitored, except in some schemes through feedback from mentees at the end of their relationship with the mentor. Even this is only realistically achievable if there is a defined end-point to the relationship – such as in schemes where, for example, GP non-principals are allowed up to six sessions with a GP mentor, who is paid per session. It is much harder to envisage a satisfactory way of monitoring a relationship, which is acceptable to all participants, if it has a much looser structure and no clear end-point. Scheme organisers no doubt 'have a feel' for how well particular mentors support their mentees but the reasons for a relationship working or not working well could be complex.

Despite the strong arguments in favour of formalisation, there are also drawbacks. Almost all current interest and activity in mentorship for doctors centres on formal schemes and formal mentorship development. Informal mentoring is regrettably associated in some people's minds with difficult power relationships, gender issues, abusive behaviour and patronage. But it would be a great loss if the best of informal, 'spontaneous' mentorship became a thing of the past. In possibly inevitable moves towards

greater formalisation of the roles of mentors we would urge that the wider approach of bringing mentorship principles into daily professional life and relationships should also be nurtured.

How are mentors and mentees best matched?

Contributors to this inquiry have expressed different views about the importance of matching from 'it's very important to have the right chemistry' to 'really, you should be able to mentor anyone'.

Techniques for bringing mentors and mentees together formally vary considerably, as has been mentioned earlier. They range from encouraging mentees to exercise free choice from a pool of potential mentors all the way to allocation of the next available mentor from the top of a list. All schemes say they allow both participants to decline the other, though how easy this is in practice is unclear. Some schemes require an initial meeting and then the mentor and mentee make a decision whether to continue, on the basis of a kind of 'contract'. In the co-mentoring arrangements, participants get to know each other during the development course and then form co-mentoring dyads or triads. This clearly works well for many but not all.

It is not easy to make sense of all this. Perhaps again, there are many issues at play, including the objectives and style of the scheme, the perceived needs of the target group of mentees and the role of their mentors, the size of the available mentor pool, the pressure on scheme organisers to demonstrate (numerical) success, and the culture in which the scheme operates.

Scheme organisers and administrators often exercise judgement about who will suit whom. Such evidence as there is would suggest that ease of meeting is important to success, for which geographical proximity, transportation, flexible and shift working and commitments outside work are central factors. Some schemes are specialty specific with both mentors and mentees from the same discipline but others deliberately avoid this, believing that many of the problems will arise from difficult relationships with close colleagues. Many hospital trust-based schemes only offer mentors from the same trust though this may be from another site which may be some distance away with mentor and mentee not working closely together clinically. Doctors taking on senior management roles may be offered a mentor from outside the employing organisation or indeed from outside medicine. Ethnic and gender issues have not featured much in this inquiry and the USA literature gives mixed messages about their importance. The conclusions appear to be that it is important to have a wide selection of mentors but that same gender and same ethnic origin matching are not important or often requested.

Some mentor development programmes employ personality measures (e.g. the Myers-Briggs Type indicator). These are not used to match individuals (mentees do not usually participate in programmes) but to help mentors better understand their own characteristics and approaches. There is a body of literature (not studied in this inquiry) from occupational psychology about the nature of mentorship interactions and predictors of success.

Overall, it may be best to rely on mentors preparing for their role in a professional manner, on genuine choice of mentors by mentees who are themselves 'street-wise' about the dynamics involved.

Should every organisation have a mentorship scheme?

This inquiry has not studied a wide range of schemes in any detail but a few conclusions can be drawn. Given the increasing number of schemes there may soon be an expectation that every trust (and possibly other organisation) should have one. The benefits to some doctors in participation in mentorship development programmes and as mentors and mentees in schemes is undoubted. But it is not yet clear

whether every organisation having its own scheme is the best way forward. Any doctor who wishes to develop mentorship skills, whether or not part of a scheme, or who requests a mentor should be given opportunities to explore the benefits. The costs of such an approach are not negligible though are small in comparison to the potential benefits. Further justification comes from the fact that these doctors are acquiring new skills that may well affect the way that they work beyond any one-to-one mentor-mentee relationship. The skills may lead to enhanced, career-long confidence in responding to difficulties in a helpful way, earlier problem solving and improved working relationships with colleagues and patients.

We therefore recommend that:

- there is a well publicised contact point for information about mentor availability in each trust, postgraduate deanery and medical royal college (preferably a person but also web-based).
- organisations that do not provide their own mentoring arrangements facilitate doctors' access to appropriate programmes and schemes.

Conclusions about the issues for exploration

- Any doctor may benefit from mentoring at any stage.
- Targeting mentoring to groups of doctors may make it easier to get schemes off the ground.
- Targeting has the potential for stigmatising those who participate and for excluding others.
- Not all doctors want or need a formal mentor.
- There are perceptual barriers to taking up offers of a formal mentor and there may be shortages of suitable formal mentors.
- Any form of overt or covert pressure on doctors to participate will be counterproductive.
- New consultant programmes may be a good way of introducing the concepts and practice of mentorship before any commitment to having a mentor is required.
- Doctors need opportunities to prepare for and develop in their new role as a mentor and it is unlikely that a one-off event is sufficient.
- Scheme organisers need to think about how formal the role of mentor is to be and make this explicit. Formalisation will be harmful if it inhibits informal supportive relationships.
- Scheme organisers need to consider whether they require any form of monitoring and how this is best done, respecting the confidential nature of the relationships.
- Schemes use a number of different ways to match mentors and mentees. Choice is important.
- Not every organisation may need a mentoring scheme but there should be well publicised points of contact for information.
- Organisations have an important role in facilitating access to mentorship.

Further information about mentoring schemes for doctors

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40053 1p 0.2k Sep 04 (EDW)

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