

Improving Working Lives for Doctors

## **Mentoring for doctors: enhancing the benefit**

A working paper produced on behalf of the Doctors' Forum

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**Produced in conjunction with two other working papers - Mentoring for doctors: talking about the experience and Mentoring for doctors: a look at the literature**

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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 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 FAQs for specialist registrars.

The Doctors' Forum website has been developed at [www.doh.gov.uk/doctorsforum](http://www.doh.gov.uk/doctorsforum) to improve communication between doctors and the DH.

### Authors' acknowledgements

We would like to express our admiration of all those who have shown inspirational leadership and personal commitment in developing and supporting mentoring arrangements for doctors. We are also greatly indebted to the very many people who have helped with this inquiry in so many ways, particularly Professor Colin Coles, Dr Jan Illing, Dr Anne McKee, Dr Zoë-Jane Playdon who provided expert reviews of the inquiry protocol and all those who gave their precious time to be interviewed.

### About this document

This document is one of three that have been produced for the Doctors' Forum on mentoring for doctors. It is available for downloading at <http://freespace.virgin.net/ncssd.org/Mentor1.pdf>

The other two comprise *Mentoring for doctors: talking about the experience*, an analysis of the over 30 interviews that were conducted as part of this inquiry and *Mentoring for doctors: a look at the literature*, a review of some of the medical literature on mentoring. They are available at:

<http://freespace.virgin.net/ncssd.org/Mentor2.pdf> and <http://freespace.virgin.net/ncssd.org/Mentor3.pdf>. (in preparation as of 29.12.03)

This document is intended primarily for doctors and managers who have some knowledge of mentoring, those who already provide support for doctors and who may be thinking of starting a new scheme or modifying an existing one.

Details of the authors and contributors are given in Annex 1 and the suggested issues for further inquiry are listed in Annex 2.

We would like to stress that we have only studied mentoring arrangements for career grade doctors in any detail. We know that mentoring is available for some doctors in training and some medical students but for them it may well have a different purpose and ethos.

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# 1. Summary of this inquiry

1. In 2002, the Doctors' Forum, established under the Improving Working Lives 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.
2. Resources were provided by the Department of Health and in autumn 2002, a search was made for mentoring schemes for doctors. Details of over 50 schemes and programmes were collated and made available to respondents. The schemes involved general practice, community practice, hospital medicine and public health medicine. Some of the schemes were well established and others very new.
3. In 2003, it was decided to extend this inquiry to gather more information about the perceived benefit of mentoring with a view to encouraging the availability of mentoring to more doctors.
4. An inquiry protocol was agreed after consultation and external review. Multi-site research ethics committee approval was obtained.
5. An anonymous interview-based inquiry has been conducted across five sites in England involving over 30 career grade doctors and managers between July and October 2003. Written consent was obtained from each interviewee.
6. A limited search and review of the literature have been undertaken. Two short workshops were held at the IWL conference on 30 October 2003.
7. It should be stressed that this inquiry has not been able to study all mentoring arrangements for doctors in England.

## What the interviews have told us<sup>\*</sup>

What do interviewees mean by 'mentoring'?

8. Mentoring is not a homogeneous, standard 'product'. There are considerable variations between schemes, particularly those which are and are not based on a co-mentoring approach, where two doctors usually of equal standing take it in turns to 'mentor' each other.
9. Yet despite these differences the central concepts are very similar - to help people to help themselves, to find their own solutions to indeterminate problems - a developmental rather than remedial principle.
10. 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.

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<sup>\*</sup> For an in depth analysis of the interviews conducted as part of this inquiry please see the companion working paper *Mentoring for doctors: talking about the experience* available from <http://freespace.virgin.net/ncssd.org/Mentor2.pdf>

## What benefits do interviewees report?

11. Doctors involved in mentoring, as either mentors or mentees, perceive the experience very positively. Medical directors who were interviewed value having a mentor as much as do newly appointed consultants.
12. A primary benefit for mentees is to have dedicated time for reflection during which someone listens 'actively', challenges their thinking and does not problem solve on their behalf, while they themselves work through their problem in a situation of trust and assurance of absolute confidence but within the ethical framework accepted by doctors.
13. Mentees also benefit by being supported and assisted in their development of strategies for dealing with the specific problems they raise with mentors. These 'problems' vary widely from checking out ideas for small changes and developments to dealing with dramatic and serious professional and interpersonal relationships. Many of the solution strategies 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.
14. Benefits for mentees who were in crisis also involve regaining self and professional confidence, feelings of self worth and job satisfaction.
15. Benefits for mentors include increased motivation and job satisfaction from pursuing and formalising a latent career interest, recognising that they have helped a colleague and 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.
16. The experience of mentoring has stimulated some doctors to establish mentoring schemes in their own locality and others to advocate much wider access to mentoring among doctors at all levels, including medical directors and undergraduate students.
17. A number of issues about the best way to structure and operate mentoring schemes and appropriate performance in the role of mentor and mentee have arisen. No single solution has been found to many of these. They include:
  - Mentor development and support – initial and on-going
  - Mentor-mentee matching
  - Mentor and mentee expectations: boundaries; purpose, getting going
  - Relationships; formality, duration, evaluation and ending
  - Employer involvement
  - Resourcing.

## What the literature on mentoring for doctors has told us<sup>†</sup>

18. Much of the literature on mentoring for doctors is from the USA. The literature from the UK is small in comparison and comprises peer reviewed papers, some

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<sup>†</sup> For a more in depth review of the literature on mentoring for doctors, please see the companion working paper *Mentoring for doctors: a look at the literature* (in preparation)

books and personal view articles. Almost without exception authors in both countries support the value of mentoring for doctors.

19. The origins of mentoring for doctors come largely from an appreciation of the value that it has demonstrated in industry and commerce and to a lesser extent in other professions. Authors also draw heavily on their own experiences of the role of mentors in developing and advancing their own careers.

#### US literature

20. The following points stand out from the USA literature on mentoring for doctors:
  - Distinctions are sometimes made in papers between the role of the mentor and the role of the teacher and the value of role models. However mentors may fulfil all of these roles.
  - Authors distinguish between formal and informal or ‘spontaneous’ mentors. On the whole arrangements that provide formal mentors are designed to help those without informal mentors benefit from this experience. Some authors believe that informal or ‘spontaneous’ arrangements are superior.
  - Much of the literature refers to faculty mentoring – a process of helping less experienced academic clinicians with their research and career development
  - The term ‘protégé’ is used frequently to describe the more inexperienced party in the relationship (the mentee).
  - Studies have shown that having a mentor is highly valued by junior faculty but many report that they do not have one, sometimes due to shortages of appropriate people.
  - The importance of having more than one mentor is emphasised by some authors.
  - Mentoring is also seen in the USA as a way of developing the academic discipline as a whole.
  - The descriptions of the role of mentors vary widely but tend to include: confidant, (academic) friend and facilitator, coach, personal counsellor, career counsellor, champion, protector, and social facilitator.
  - Details of how the relationship is or should be conducted are not commonly given. One key to success emphasised by some authors is having sufficiently frequent meetings.
  - Cross gender and cross cultural issues feature prominently in papers though having a mentor of the same gender and race is not thought necessary by most authors.

#### UK literature

21. The literature in the UK covers hospital practice and general practice and reference is made both to doctors in training and career grades.
22. Those who write about mentoring 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.’<sup>1</sup>
23. Broadly there are two types of mentoring relationship described in the UK literature:

- a) Where there is a hierarchy of experience between mentor and mentee and the benefit is seen largely as flowing in one direction: ‘a process in which a more skilled or experienced person (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.’<sup>2</sup>
  - b) Where there is not necessarily a hierarchy of experience between mentor and mentee and in which roles may be reversed during the same meeting (called co-mentoring or co-tutoring): ‘a dialogue between two autonomous practitioners on a voluntary basis.’<sup>3</sup>
24. One of the key ingredients in some mentoring programmes is the skill of ‘active listening’ which is distinguished as being purely to assist those who are speaking, helping them to explore their thoughts and experience at their own pace without interruption. ‘Listeners do not offer solutions, but try to enable those speaking to find their own.’<sup>4</sup>

## Main findings and recommendations

### Findings

25. Our main findings from this inquiry are as follows:
- a) The SCOPME conclusions and recommendations published in 1998 are still largely valid.
  - b) There is now influential support for mentoring for doctors and many schemes have been started.
  - c) There are many shared understandings about mentoring’s main objectives, and principles and values that should underpin it
  - d) There are just as many differences in terms of the organisational processes that have been adopted.
  - e) 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.
  - f) Doctors can benefit from participation in mentoring at almost any stage of their careers.
  - g) 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.
  - h) There is a widespread agreement that mentors benefit from preparation for this role but opinion varies about the extent of this requirement.
  - i) There is little evidence that mentees are prepared for their role, except as part of co-mentoring arrangements.
  - j) 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

26. Based on the findings from our inquiry, we recommend that the benefit from mentorship arrangements for doctors will be enhanced when:
  - a) Mentoring is promoted as a natural way by which doctors can enhance their careers.
  - b) participation remains entirely voluntary.
  - c) access to mentorship schemes is made as wide as possible.
  - d) doctors can choose the scheme in which they participate
27. We further recommend that:
  - e) 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.
  - f) authors, speakers at meetings, development programme providers and scheme organisers describe in detail what they are referring to when they use ‘mentor’, ‘mentoring’ and associated terms.
  - g) awareness of mentorship principles and skills is promoted as part of other courses on clinical and educational supervision, management, appraisal and educator skills development, etc.
  - h) 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).
  - i) organisations that do not provide their own mentoring arrangements signpost doctors to appropriate schemes.
  - j) opportunities to develop mentorship skills are included in arrangements for continuing professional development (CPD) and funded accordingly.
  - k) further evidence is collected as soon as possible on the issues for further inquiry set out in this working paper.
28. Finally, as the literature on UK arrangements for mentoring for doctors is still quite small, we recommend that
  - l) scheme organisers describe and evaluate their schemes and seek publication of the findings in searchable journals.

## 2. Introduction

29. This working paper has been produced for the Improving Working Lives (IWL) Doctors' Forum and is intended to be helpful to those considering providing mentoring opportunities for doctors. It is also intended as material for discussion and feedback by those who have already started schemes within their Trusts or other organisations for doctors.
30. The document is based on a number of sources of information and advice. They include:
  - The 1998 SCOPME report *Supporting Doctors and Dentists and Work: an inquiry into mentoring*<sup>5</sup>. (SCOPME's conclusions and recommendations are set out later).
  - A collation of mentoring schemes for doctors (largely in England) assembled in 2002 (unpublished).
  - A review of some of the UK and US literature on mentoring for doctors.
  - A research report based on over 30 interviews of doctors and NHS managers conducted by a team of interviewers during 2003.
  - Two workshops at the second IWL for doctors conference on 30 October 2003.
  - Other material about mentoring schemes for doctors and other input from colleagues.
31. The views expressed in this paper are based heavily on the above inputs but are also influenced by the authors' own experience and views. Details of the authors and other contributors to this working paper can be found at Annex 1

## Background

32. Mentoring for doctors in its widest sense has been in action probably since medicine was recognised as a profession. Sharing information, experience and wisdom is part of the medical ethos. Often these processes go by other names but drawing on the knowledge and wisdom of others is an essential part of mentoring.
33. More recently mentoring for doctors has become in some quarters a more formal process with its own principles and values and a range of processes that have been formed by local enthusiasts influenced by the prevailing circumstances and values in each health care sector.
34. In formalising mentoring into a recognisable process, medicine has drawn heavily on the experience of industry and commerce but it is now beginning to establish a tradition and literature of its own.
35. In its 1996 the Standing Committee on Postgraduate Medical and Dental Educations (SCOPME) was asked by the then Chief Medical Officer to inquire into current beliefs and practices in mentoring for doctors. This request was motivated by concerns about seriously underperforming doctors for whom mentoring was thought to be one possible solution. The Committee's inquiry (chairman: Professor Dame Barbara Clayton) was headed by a working group chaired by Dr Trevor Bayley and the inquiry was conducted by Dr Annabelle Baughan. SCOPME's conclusions and recommendations, published in 1998 are set out in full here:

### **SCOPME conclusions**

1. There are many and varying concepts of mentoring as shown in the large literature on mentoring in the professions other than medicine and dentistry. A useful description of mentoring based on a synthesis of concepts might be:

*The process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee.*

2. Based on the findings from other professions and the important initiatives underway in medicine, mentoring can form a valuable part of a framework of support for doctors and dentists which is personal, professional and educational.
3. Mentoring should be entirely voluntary and not imposed. Confidentiality is essential.
4. It is important that both mentors and mentees understand fully the purpose and limits of the mentoring relationship. Development programmes for potential mentors are needed.
5. Local analysis of the support that doctors and dentists need should precede attempts to bring in formal arrangements for mentoring.
6. There are likely to be different support needs at different stages of a career. There is a perceived need for extra support for newly appointed GP principals, consultants, those in non-consultant career grades and pre-registration house officers. Formal arrangements for mentoring may be particularly valuable at these career stages.
7. There is much to be gained by informal peer support but the need for this has to be recognised and a suitable time and place made available. Any initiatives to bring in more formal systems of support, such as mentoring, should complement informal support and not seek to replace it.
8. Local improvements in support could involve other health professionals.
9. Some support time needs to be away from the workplace.

### **SCOPME recommendations**

1. There should be local analysis of the need for support for doctors and dentists and local decisions made about the provision of such support.
2. Where possible, working conditions should be adjusted so that doctors and dentists can gain maximum benefit from informal peer support.
3. For the purposes of these recommendations and for the wide debate that SCOPME hopes will follow, mentoring for doctors and dentists should be taken to mean:

- A voluntary relationship, typically between two individuals, the mentor and the mentee in which:
  - The mentor is usually an experienced, highly regarded, empathic individual, often working in the same organisation or field as the mentee;
  - The mentor, by listening and talking with the mentee in private and in confidence, guides the mentee in the development of his or her own ideas, learning, and personal and professional development.

- Mentoring should be a positive, facilitative and developmental activity and is not related to, nor forms part of, organisational systems of assessment or monitoring of performance.
4. The concept of mentoring, as one way of meeting the support needs of doctors and dentists, with its potential benefits and risks, its aims and processes should be made known widely.
  5. Opportunities for mentoring should be made widely available within medicine and dentistry, but should not be imposed.
  6. Where opportunities for mentoring are made available formally:
    - Mentoring should be developed locally through explanation and discussion and in conjunction with explicitly stated support from organisational leaders, both nationally and locally;
    - Local implementation can usefully involve other health care professions, including human resource professionals both as mentors and as local experts on the introduction of mentoring;
    - Mentoring must be separate from the external monitoring and assessment of performance, promotion and remuneration;
    - Some mentoring opportunities are available away from the doctor or dentist's workplace.
  7. Those volunteering to become mentors should be given appropriate assistance to develop their skills.
  8. Development programmes for potential mentors should be encouraged and evaluated.
  9. Mentoring for newly appointed career grade doctors and dentists should be considered a priority.
36. Although this present inquiry was not intended as a direct follow-up to SCOPME's findings, it has shown that they are still highly relevant. Respondents to a request in 2002 for details on mentoring schemes for doctors showed that they relied very heavily on SCOPME's advice. Findings from the literature review and the interview study in 2003 have also supported this advice although there have been developments in terms of descriptions of mentoring and operational processes.

### Support for mentoring for doctors in 2003

37. There is now considerable official support for mentoring opportunities to be provided for doctors. Many of the leading medical organisations have taken forward their thinking around mentoring. However, the drivers for supporting it vary considerably. Some examples are given here to illustrate this. We are grateful to officers of the organisations mentioned for providing much of this information.

#### The Department of Health

38. In para 8.26 the government's *NHS Plan*<sup>6</sup>: states:

The new consultant contract will make clear that in the early and middle part of their careers, consultants will be expected to devote the bulk of their time to direct clinical care. It will also stipulate, however, that towards the end of their careers, consultants will have the flexibility to reduce their fixed clinical sessions without detriment to their pensions. We envisage a greater role for mentoring, training and leadership, for example.

39. In 2002, the Department of Health issued *International Recruitment of Consultants and General Practitioners for the NHS in England*<sup>7</sup>. This publication provided

guidance to NHS employers on an infrastructure to support international recruitment. A successful infrastructure to support medical international recruitment should include:

mentoring by a medical colleague, ideally from the same specialty or general practice. If this is not possible the mentor should be a senior colleague, preferably a clinical director.

40. The Department's Improving Working Lives for Doctors booklet<sup>8</sup> highlights the mentoring support networks available to hospital doctors and GPs in the north east of England. Mention is also made by the Department of Health Steering group responsible for the integration of refugee health professionals into the NHS of the importance of mentoring for refugee doctors to help them with the IELTS examination.

#### British International Doctors Association (ODA)

41. The British International Doctors Association (formerly known as the Overseas Doctors' Association) set up mentors in all specialties in 1998 and in all regions in the United Kingdom. Most mentors are consultants, and not all are from overseas as many British doctors have also become involved in the scheme.

#### British Medical Association (BMA)

42. The British Medical Association's Board of Medical Education is currently producing guidance on mentoring as support for all doctors and students, in response to a resolution carried at the BMA's annual representatives' meeting in June 2003 that stated:

This meeting insists that the BMA lobbies for the development of a mentoring system for all doctors and calls on the government to resource this appropriately.

43. The BMA's International Department has responded to the needs of refugee doctors and its website<sup>9</sup> states:

Refugee doctors face a variety of hurdles in order to resume their medical careers in the UK, and the process can be lengthy and can undermine their self-confidence. Contact with fellow health professionals, and a strong support network are vital to ensure that they remain motivated.

Doctors are being offered the opportunity to act as mentors for refugee doctors wanting to practise in the UK.

The Refugee Education and Training Advisory Service (RETAS), a member of the BMA-convened Refugee Doctor Liaison Group, has received funding from the Health Department to set up a mentoring scheme across England. The role of a mentor will be to explain the way the health system works in the UK, and to help and support refugee doctors through language exams, including the Professional and Linguistic Assessment Board tests.

44. In the introduction to its October 2003 position statement in response to *Modernising medical careers* the BMA states:

Career advice for students and doctors is essential, and must help them to make informed and appropriate choices from the full range of career options available. It should enable switches in career direction and facilitate mentoring. It should include specific advice and mentoring for those interested in careers outside the mainstream and careers currently facing a critical shortage, such as clinical academia.

45. The joint statement of agreed principles on a new framework for discipline and suspension drawn up by the BMA Central Consultants and Specialists Committee and the Department of Health<sup>10</sup> states:

The outcome of any investigation will be discussed with the doctor concerned. A range of options such as no case to answer, re-education, supervision, mentoring, a change in the employer's working systems or referral to occupational health should be explored.

#### National Clinical Assessment Authority

46. The National Clinical Assessment Authority (NCAA) has provided us with the following information:

The NCAA is currently developing a web-based toolkit to help NHS managers think through local performance management systems and consider how they might be made more sensitive. The NCAA is encouraging mentoring as a developmental and support tool, in a range of non-investigatory and non-disciplinary contexts.

#### Academy of Medical Sciences

47. In one of its early reports<sup>11</sup> the Academy of Medical Sciences recommended that doctors wanting to achieve a CCST as well as continue their research training (clinician scientists) should be provided with a mentor drawn from the Academy's fellowship. Its mentoring scheme has been in operation since 2000 and is now supported by the Department of Health and other medical charities. The scheme is open to all clinician scientists who hold an academic national training number [NTN(A)] and has achieved a high uptake. Discussions are taking place about extending the scheme to other clinical academics.

#### Medical Royal Colleges

48. The Court of Electors of the Royal College of Psychiatrists approved a document in June 2002 which recommended:

that all newly-appointed consultants should have access to a designated senior colleague – a Mentor (or Mentors) – to whom they could turn (in person, by telephone or via electronic mail, if preferred) for advice, support or information in these crucial early days.

49. The Council of the Royal College of Paediatricians and Child Health approved a document in 2002 in which the following recommendations were made:

The College should consider establishing a number of Paediatricians who are well respected within the profession, and who would be willing to make themselves available as mentors.

The College should offer training to assist potential mentors and consider the need to avail itself of the services of a trained Counsellor to assist in this task.

The College should make the availability of mentors widely known, through the Regional College structure, offering the opportunity for Paediatricians, experiencing difficulty, to contact, in complete confidentiality, a mentor from outside their own Region who would be willing to provide support.

Care must be exercised to ensure that mentors are appropriately qualified to fulfil their role; that they are not overburdened, that they are offered an easy option to "opt out" if they consider themselves inappropriate to the task and that mentors are not appointed who may abuse the role.

50. The Royal College of Obstetricians and Gynaecologists (RCOG) has set up a mentoring Scheme for obstetricians and gynaecologists who have voluntarily contacted the College to seek a mentor because they have been experiencing difficulties in relation to their work. RCOG mentors are Fellows/Members of the College who have undergone mentoring training and come from a range of backgrounds and localities. Guidelines are available on the RCOG website at [www.rcog.org.uk](http://www.rcog.org.uk) and cover the mentor's role, the process, method of working and funding, ethical issues, alternative support services and feedback forms.

51. The Royal College of Ophthalmologists is committed to offering all ophthalmologists access to a mentor:

Consultant ophthalmologists in each deanery will be identified who are prepared to act as local mentors and they will receive training and support from the college. Mentors will be paired so that co-mentoring can occur across deaneries.

When the College is notified of a consultant appointment the college will offer the appointee access to a mentor in their deanery. The mentor will make first contact and check that the mentee is happy to proceed. All mentoring activity will be confidential but the College will ask if mentoring is active with mentees.

The purpose of mentoring is to provide newly appointed consultants with access to a 'buddy' or 'informed helper' who is independent of the organisation in which they work. The depth of the mentoring relationship will be determined by the mentee and mentor within an agreed framework. Mentors and mentees will be made aware of the signs of a dysfunctional mentoring relationship and what to do about it. It is important that all newly appointed consultants are offered a mentor so that there can be no inference that seeking a mentor means professional weakness. All mentees will work with their mentor in a voluntary way and will not be coerced.

The identification and training of mentors will begin in the New Year, 2004.

52. The Royal College of Surgeons of England has provided us with the following information:

The Royal College of Surgeons of England is currently looking into how the College can best support and promote mentoring schemes for surgeons at all stages of their career. The concept of mentoring is inherent in the College publication 'Good Surgical Practice' (2002) and the College wishes to build on this by investigating ways of developing a mentoring culture within the College structure and encouraging involvement in local schemes

53. The Royal College of Radiologists (RCR) has provided us with the following information:

The RCR has no formal programme of mentoring for consultants. The College does, however, through its publications, make clear that College Officers are available to offer advice and support to Fellows and members. Similarly, the College offers to nominate mentors to those Fellows of the College who find themselves in difficulty for reasons of health or alleged poor performance.

Through its Service Review Committee the College investigates situations of conflict, alleged poor performance and operational difficulties in Departments of Clinical Radiology and will, where necessary, nominate an experienced Fellow to provide support and advice to individual(s) within the department.

54. But perhaps the most powerful indicator of the perceived value and current enthusiasm for mentoring comes from the 2002 collation of mentoring schemes for doctors. Details of over 50 schemes and programmes were assembled and there was evidence that there were many more. Some were established and others had just

started. A few schemes had, however, wound down because of lack of support locally.

## The objectives of this document

55. We hope that this working paper makes a useful contribution to:
  - providing a review of current concepts of mentoring for doctors
  - sharing practice across the health sectors
  - suggesting areas in which there appears to be a broad consensus
  - showing the range of views about many of the issues
56. It is also intended as a stimulus for further work and we have identified some issues for further inquiry in Section 6 and listed them for convenience in Annex 2.

### 3. Shared understandings about mentoring for doctors

57. It is apparent from this inquiry that we are considering very complex issues. They involve doctors' personal and professional lives, their roles as professionals in different health care sectors, each with its own pressures and challenges and their capacities as managers, employers, employees and independent contractors. Doctors are driven by their dedication to care for patients in a climate of professional uncertainty, continuing change and increasing demand.
58. It is not surprising therefore that mentorship should be seen by some as a helpful way of obtaining information and guidance for use in establishing themselves quickly in a new role and achieving even greater success. Others, however, view it almost as a haven in a storm, a safe place and time for unfettered sharing of their hopes, ambitions, fears, difficulties and uncertainties with someone they trust. That we have found a very complex picture in terms of perceptions, intentions and arrangements for mentorship reflects the diverse personalities and experience of doctors and the world that they live and work in.
59. Many contributors have regretted that there is not one shared meaning of the term 'mentoring' or one intended purpose. But we also feel that many now understand and have come to value that there is a range of purposes and processes, all called 'mentoring'. In terms of purpose these range from helping already very successful people achieve even more to providing support to those who are struggling or who face criticism. The variety of processes used could be described as ranging from:
- an experienced person passing on knowledge, experience and wisdom to one less experienced in an informal, developing and possibly close, personal relationship that may last many years
- all the way to:
- a pre-determined activity, usually but not always between two people, who are sometimes but not always of equal standing, which is highly structured and time-limited.
60. Such diversity in the interpretation of mentoring also highlights the way in which developmental or educational strategies are influenced by a multitude of factors, making homogeneous implementation inappropriate.
61. Authors have subdivided mentoring into different types (e.g. career mentoring, personal mentoring, research mentoring and pseudo-mentoring) but these additional terms have not been taken up widely. Their value is doubtful as again there is an intended meaning which may not be obvious. Rather than trying to find and impose one meaning, it is perhaps more useful to request that authors and speakers at meetings describe what they are referring to when they use particular terms. Using 'mentor' and 'mentoring' to cover almost any activity associated with learning assisted by another person is not at all helpful.
62. But alongside the wide diversity of views about many aspects of mentoring for doctors, there appears to be broad agreement about a few key issues. These relate mostly to:
- Ethical considerations
  - Benefits of mentoring

- Distinctions and boundaries
- Mentor preparation
- Project management
- Resources

#### *Ethical considerations*

63. Virtually all authors and contributors to this inquiry agree that the intention of mentoring arrangements is to benefit the individuals concerned, mostly, though not exclusively, the people who are considered to be the mentees.
64. Most also agree that the relationship should be entered into voluntarily. There are some issues around how participants select and ‘de-select’ each other and whether the relationship can be considered fully voluntary if a mentor is appointed by a third party. These are considered later.
65. All contributors agree that what takes place in discussions (however conducted) between mentors and mentees - or listeners and speakers in the co-mentoring schemes - are confidential to the people involved.
66. But it is also agreed that this confidentiality is constrained by the ethical framework in which doctors practise. Should any harm to patients, participants, colleagues or organisations become apparent to any of the participants, it is agreed that other mechanisms have to be brought into play.
67. Although NHS management (medical and executive) has a clear interest in the success of mentoring arrangements, it is largely the case that management does not expect to be privy to these discussions nor requires any reporting arrangements to be in place, other than evidence of the good conduct of schemes. Some managers require some knowledge of the participants.

#### *Benefits of mentoring*

68. There is wide agreement that many, possibly most, doctors who engage in mentoring benefit from the experience in some way or another. For some the impact is huge.
69. Although there is much interest in providing mentoring for specific groups of doctors, such as new consultants and GP non-principals, it is also clear that doctors at any stage in their careers may benefit. Further the benefit is seen in tackling new roles and taking control of personal and professional development, as well as addressing immediate problems.
70. Some organisations for which doctors work also recognise the benefits but reasonably ask questions about purpose, process and return on investment.
71. The benefits reported to us are summarised in Section 5 and given in detail in the companion working paper *Mentoring for doctors: talking about the experience*.

#### *Distinctions and boundaries*

72. There is widespread agreement that mentoring is a process distinct from appraisal, performance management, and clinical supervision. It is underpinned by different concepts and processes and has different outcomes.
73. There are, however, constructive interfaces with formal educational processes (for example, with personal development planning arising from appraisal) and with patient care. In the view of some, there is a role for mentoring for doctors who need

support because of performance difficulties that have become known to colleagues and management.

74. It is likely that the skills needed for educational support, clinical supervision and appraisal may be enhanced by an awareness of, and skills in, mentoring.
75. Many colleagues fulfil different roles at different times - a medical director who is also a mentor and mentors who also act as appraisers are two examples. The potential for role conflict is clear but most agree that it can be managed.

#### *Mentor preparation*

76. Almost all agree that doctors who are to assume formally the role of a mentor benefit from some preparation before taking it on. The term 'preparation' is used deliberately because arrangements differ widely in terms of what this involves. It ranges from relying on experience gained in other roles, such as academic supervision and continuing education, to requiring participation in mentor skills courses spread over many months.

#### *Project management*

77. Whereas informal or spontaneous mentoring requires little, if any, direct management, formal schemes require administrative support and project management by people with time allocated for the task.

#### *Resources*

78. It is widely agreed that providing formal arrangements for mentoring is not cost neutral in the short term. Money and/or paid time are required for most of the activities associated with mentoring and adequate funding for at least two years appears to be essential to start and develop schemes.

## 4. Mentorship arrangements for doctors

79. This section summarises briefly the range of activities that take place in the name of mentoring and shows how these have been formalised into recognised schemes. As we have not undertaken a detailed comparison of different arrangements, most of the comments are general in nature.
80. The US literature<sup>‡</sup> is very strong on the benefits of what might be called traditional one-to-one mentoring (referred to as ‘mono-mentoring’ in the companion working paper *Mentoring for doctors: talking about the experience*) provided by an older more experienced person which may turn into a personal (though advisedly non-sexual) relationship which develops over time and which may last for years. These relationships are considered very important and doctors holding high office often mention the people that have helped them develop their careers in this way.
81. The US literature also reveals that whereas these relationships are highly regarded in academic circles, not everyone identifies that they have a mentor and indeed some disciplines point to the shortage of mentors particularly among women and ethnic minorities. Papers also reveal that changing pressures on academic staff have squeezed out the time available for helping younger colleagues.
82. Some academic disciplines see mentoring as a crucial way of helping younger colleagues with their research and career development and also as a way of attracting young doctors to enter and stay in the discipline, thereby sustaining the discipline itself. The literature mentions the importance of mentor-seeking skills and behaviour on the part of the junior members but less is said about how these can be advanced.
83. In some ways, formal arrangements for providing designated mentors are a response to some of these issues. Evidence is adduced by some authors that formalising mentorship relationships can provide many of the benefits that accrue from spontaneous relationships at the same time as overcoming some of the barriers that exist to these relationships forming. Others are not so sure, suggesting that spontaneous relationships are stronger because they avoid the process problems (discussed later), do not require specific outcomes and because the relationships may last much longer.
84. Interestingly the UK literature (at least that revealed in our search for papers using the terms ‘mentor’ and ‘mentoring’) focuses much less on the impact of particular individuals as mentors, preferring to discuss the formal arrangements in which perhaps the personality of the mentor is in some ways less important.
85. There are perhaps two main antecedents of formal mentorship in the UK though both perhaps are a response to professional isolation. In general practice, the move to provide mentors for GPs had its origins partly in the need to help GPs engage with continuing education and professional development with a focus on personal development planning. In the hospital sector, the needs of women doctors were originally one of the main triggers.

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<sup>‡</sup> Please see the companion working paper *Mentoring for doctors: a look at the literature* available at <http://freespace.virgin.net/ncssd.org/Mentor3.pdf>

86. More recently particular groups of doctors, for example, those at a time of transition (e.g. new consultants) those working flexibly (e.g. GP non-principals), those taking on new management roles (e.g. medical directors) and those with performance problems have featured as perhaps benefiting most from mentorship opportunities. Doctors of both genders in all career grades are now included in mentorship arrangements and the benefits are found to be very wide ranging (see Section 5 for more on this).
87. Different models have also emerged which reflect the circumstances of their inspiration and application. It is perhaps helpful to distinguish mentorship *development programmes* (often, in our view, inappropriately called ‘training’ programmes) from mentoring *schemes* that select and match mentors and mentees and support these relationships in other ways. Clearly the ethos and content of the chosen mentorship development programme will have a big influence on the way that mentorship is subsequently practised in the hospital, community or the primary care setting. However, we have little knowledge about the inevitable modifications, attritions and creative developments that take place once the relationships start.
88. An interesting difference in approach lies in the extent to which mentorship development programmes do or do not rely on participants being in a one-to-one relationship with a mentee. Some make this a requirement although the actual mentees are absent from the programme. Others programmes provide the forum in which mentor-mentee partnerships are formed (e.g. the co-mentoring schemes) and enable all participants to adopt and practise both roles, an interchange that they will continue afterwards ‘for real’. Other programmes do not rely at all on there being a mentee ‘waiting in the wings’, preferring to help participants learn mentorship skills from all perspectives with a view to relationships being formed at a later date or not at all.
89. Mentors are inevitably strongly motivated to learn when they are already committed to a mentoring relationship (or when two or more people sign up to a co-mentoring arrangement) and the practical experience of ‘live’ mentoring further enhances their learning. On the other hand, one possible spin-off from unhooking learning about mentorship from having the responsibility of a mentee is that it may allow learners to:
  - implement their skills more widely in their professional lives
  - make themselves available to be a formal mentor only when they feel ready
  - be more open to requests for informal mentor help from doctors who are not designated as ‘their mentee’.
90. The mentorship development programmes have many elements in common, one of the most important being the skill of ‘active listening’, described as being different from ‘diagnostic listening’ as the listener is required to hear everything that is said and to suspend evaluation so the listener’s opinions do not colour understanding of the speaker’s situation. The programmes differ in length, the amount of time they give to skills practice and the emphasis they place on the role of mentoring in organisational development. Many but not all provide opportunities after the initial programme for refreshment and rehearsal of skills and opportunities for mentors (but again rarely mentees) to share success and problems and to review progress.

91. Some mentorship schemes are inextricably bound in with the development programme e.g. the Anglia co-tutoring programme. Participants learn about and practise the skills of co-tutoring during the 2-day programme, at the end of which they form co-tutoring dyads (two people) or triads (three people). Co-tutors make a commitment to meet subsequently and opportunities for further practice and review for the all participants in a programme are provided annually. In other schemes, the mentorship development programme is provided by a visiting organisation either on- or off-site with the administration of the scheme itself being provided by the Trust. In some cases the visiting organisation will also provide advice and support for the scheme administration and development within the Trust or other host organisation.

## 5. The benefits of mentoring

92. We consider that the evidence is very strong that for some doctors, mentorship is a very powerful tool in achieving personal and professional goals. The literature from other professional sectors on the benefits of mentoring is extensive but we feel it is very important to reflect what doctors are saying currently about their experiences. The statements in this section are therefore drawn largely from the companion working paper *Mentoring for doctors: talking about the experience*, based on the interviews we conducted between July and October 2003. Much more material with extensive quotations can be found in the working paper.
93. The people we interviewed identified benefits which can be grouped under three main headings:
- General benefits to individuals
  - Help with specific problems
  - Benefit to organisations.

### General benefits to individuals

94. These were identified by interviewees as follows:
- A positive response to the experience of mentoring both as mentor and mentee
  - The value of the time for reflection set aside from the hurly burly of professional life
  - The value of having someone to go to who would make you feel you were being well listened to
  - The value of being able to address problems and dilemmas in a risk free environment
  - The value of dealing with real problems during mentoring development programmes
  - The value of the action orientation of mentoring – finding ways of addressing real problems
  - The value of seeing another's point of view and the ability to challenge one-sided views.

### Help with specific problems

95. A number of mentees reported that mentoring had helped quite dramatically with serious problems they were encountering in their professional lives, some as new consultants, some as more experienced consultants and medical managers and some as both principals and non-principals in general practice.

### Regained confidence

96. Many benefits centred on regaining personal and professional confidence that had been undermined by a feeling of loss of control over their professional lives and an accompanying sense that their competence was at risk. The experience of mentoring had given them confidence to, for example,
- take control

- take action on matters which had previously been ‘pending’
- manage complex job responsibilities
- deal with difficult relationships
- be themselves
- remain in the profession
- leave the profession
- extend their professional roles and activities.

#### Job satisfaction

97. Regained confidence was often associated with increased job satisfaction, but the latter was also associated with the satisfaction of being a skilled helper, of being able to help colleagues address problems.

#### Dealing with relationships and team working

98. Many of the issues mentees raised are concerned with relationships with colleagues and relationships within work teams. Many reported ways in which mentoring had helped them address and resolve these issues and improve their working relationships with colleagues. For some mentoring helped address such difficulties at an early stage or provided them with strategies for reducing team conflict and building a consensus.

#### Problem solving

99. A clear reported benefit of mentoring was the ways in which it helped to identify the core of the problem, to ‘get to the nub of the problem’, understand the underlying issues.
100. Participants also reported developing new ways to approach and manage problems as well as coming to understand their problems in different and sometimes surprising ways.
101. The experience of mentoring was described as empowering, liberating and associated with an increased feeling of well being.

#### Leadership

102. For some leadership is considered the essence of mentoring and more than one of the mentorship development programmes have leadership as one of their central tenets. The particular aspects of leadership referred to included increased creativity, increased confidence in a leadership role and a greater understanding of the perspectives of others.

#### Professional development and education

103. For some mentoring was of particular value in identifying educational needs, making career choices and clarifying a sense of professional identity and purpose.

#### Collegiality

104. Many mentoring schemes offer opportunities for mentors to meet on a regular basis to reflect on their experiences and provide mutual support. These opportunities are

greatly valued by some doctors, especially those working in relative isolation from colleagues.

#### Use in appraisal

105. A number of doctors are finding that their mentoring concepts, principles and skills have a valuable place in conducting appraisal with colleagues. In at least one scheme the use of a mentoring approach in appraisal seemed to have all but replaced the original mentoring activity.

#### Benefit to organisations

106. The involvement of healthcare organisations in mentoring varies from nil to almost complete incorporation, with examples at the nil end less prevalent than those with some intermediate or almost complete level of organisational ownership and control. Minimal organisational involvement occurs where mentoring schemes are provided 'off the peg' and administered by external mentorship development programme providers.
107. Organisational involvement can include:
- Less frequently: negotiation of aspects of the mentorship development programme
  - More frequently: selecting mentors; selecting target mentee groups, e.g. new consultants; arranging mentor-mentee matching; arranging mentor support.
108. Trusts acknowledge that assessing benefits to them as organisations is difficult and imprecise. Some medical managers speculate that mentoring ought to reduce negative events such as referrals to the General Medical Council, the time the medical director spends dealing with 'difficult' doctors or the opportunity to air problems at an early stage, reducing the risk of major and escalating difficulties. Equally medical and other managers acknowledge that such indicators as retention and reduced absence through illness and stress related disorders are also difficult to relate to mentoring, other factors being involved.
109. In the absence of precise measures some participants commented on disappointing take up rates (30 per cent or less) and others on the ambiguity of take up figures – a kind of inverse 'help' law – are those most in need least likely to take up the opportunity?
110. Mentoring was recommended as a general organisational approach for managing transition points in professional careers.
111. The visibility of the investment costs of mentoring varies depending on the health sector. In general practice the time costs are more frequently recognised and reimbursed. In the acute sector mentoring is not yet recognised in job plans although the costs of mentorship development programmes are often met by the Trusts.
112. Investment in mentoring arrangements for new consultants was considered likely to yield the highest benefit for the costs involved.

## 6. Issues about mentoring for doctors

113. In this section we look at some of the current issues of concern. We have restricted ourselves to issues that have emerged in this inquiry although we expect that there may be others that require attention. We also put forward some suggestions for further work (listed together in Annex 2) that may help mentorship for doctors in the UK progress and make the best use of the current support and enthusiasm for mentoring that is so evident.

### Who needs mentoring?

114. The evidence from this inquiry is that almost any doctor may benefit from mentoring at different times in their lives and careers. Traditionally, it has been thought that a period of transition, such as when taking on a new role, is the time when many will seek a mentor and that the need for this support wanes as the person develops greater confidence, knowledge and skills. Although some of the contributors to this study confirmed that mentorship was useful to them in a new role, it was also clear that there are many other situations that cause doctors to look for additional support.
115. Targeting specific groups can certainly assist schemes to get off the ground. It makes it easier to estimate the size of the task ahead, make the necessary business case and raise the necessary funding. It may also make monitoring, evaluation and development easier.
116. But there are problems with targeting mentoring at specific groups of doctors. Mentoring may not be the most (cost)-effective tool. If, for example, there are enough doctors in a particular group 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.
117. 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. If the role of the mentor is cast as widely as some authors have done, 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. We would also like just to interject one comment from a US author who reflects on the limitations of mentoring thus:
- 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 [mentee].
118. An additional downside of targeting mentoring at specific groups of doctors was mentioned by participants at one of the workshops – that of stigmatisation. Very regrettably within medicine there still seems to be a view that requesting or offering additional help implies a weakness or lack of readiness in the recipient, rather than a valuable opportunity to gain extra insights to allow the recipient to achieve even greater success.

119. 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, such as in education or management, or when they are facing difficulties in their professional and personal lives.
120. Providing a mentor for doctors in a particular grouping, where the mentors are not themselves part of that grouping, also overlooks the strength of peers sharing experience and support and developing peer networks.
121. SCOPME in its 1998 report 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.
122. There is a possibility that providing arrangements for doctors to be mentored might almost be an easier option rather than tackling wider and deeper cultural issues and institutional and professional pressures that make it necessary in the first place. We would deeply regret this.
123. Although mentorship for doctors is not universal at the present time, it is perfectly possible that more doctors might be drawn to formal arrangements if they had a choice of schemes, such as own Trust based, other Trust based, deanery based, royal college based, etc, each with its own characteristics and requirements.
124. Undoubtedly, though, contributors to this inquiry and studies in the published literature report enormous benefits from being in a one-to-one formal relationship with a senior colleague or a peer. In the absence of clear evidence about exactly who will benefit from mentoring, it may be best to ensure that:
  - a) mentoring is promoted as a natural way by which doctors can enhance their careers.
  - b) participation remains entirely voluntary.
  - c) access to mentorship schemes is made as wide as possible.
  - d) doctors can choose the scheme in which they participate
 We further recommend that:
  - e) 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.
  - f) authors, speakers at meetings, development programme providers and scheme organisers describe in detail what they are referring to when they use ‘mentor’, ‘mentoring’ and associated terms.
  - g) awareness of mentorship principles and skills is promoted as part of other courses on clinical and educational supervision, management, appraisal and educator skills development, etc.
  - h) 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).
  - i) organisations that do not provide their own mentoring arrangements signpost doctors to appropriate schemes.
  - j) opportunities to develop mentorship skills are included in arrangements for continuing professional development (CPD) and funded accordingly.

## Issues for further inquiry<sup>§</sup>

125. Based on the above considerations, we suggest it would be helpful to gather information about:
- doctors who participate in schemes that do and do not target mentorship at particular groups of doctors, with particular reference to points b) to e) in the previous paragraph.

## Why don't some doctors ask for a mentor even when offered one?

126. It is certain that all doctors have been influenced during their careers by other people in ways similar to those described as mentoring. These people may not be consciously identified as mentors at the time, if ever. It is possible therefore that the support needs of doctors who do not request a mentor may be fully met in other ways and there are some clues that highly successful doctors are also good at finding informal mentors and therefore do not require to participate in formal schemes – they have well developed mentor seeking skills.
127. We also know, however, that there are barriers to participation. There may be:
- ignorance of what mentoring is all about and/or multiple interpretations of what mentoring may entail
  - or a suspicion that it is a covert managerial process
  - or a lack of willingness to trust another, maybe unknown, person with personal issues or problems that might imply professional failures
  - or a lack of perceived need as there are no obvious current problems to be solved.
128. Some of these will be overcome in time as mentoring becomes more widely known and accepted but strategies to 'introduce' doctors to mentoring seem to be very worthwhile. Contributors have reported a number of ways of doing this including:
- providing written information about a scheme
  - publishing 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 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.
129. Contributors have emphasised that mentees can always 'change their mentor' (less commonly vice-versa). However, it is unclear what level of confidence and skills 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 possible repercussions may be powerful deterrents to changing mentor.

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<sup>§</sup> The issues for further inquiry are listed together in Annex 2

130. A somewhat different approach involves ‘taster’ events being organised that provides insight and experience of the principles and practice of mentorship without any prior commitment to participation in a relationship.
131. Although not reported to us in this inquiry, it would seem that such an event could usefully be incorporated, for example, into new consultant programmes. If established consultants, who will be the mentors, participate in this event and demonstrate appropriate mentorship skills and attitudes, some of the mentees’ concerns around trust and choice of mentor may be relieved. Mentees may also be able to share with each other any concerns about participation in a mentoring relationship in private, peer-group discussions. They may also then be able draw on their collective experience to resolve some of the issues that would perhaps otherwise have to be taken to the mentors.
132. Despite strategies to encourage doctors to participate there will be those, possibly many, who will not do so – or at least, not until they are ready. Although it has also been reported to us that doctors who do not respond to offers of a mentor are those who may run into difficulties, we consider that this decision should be respected and their needs met in other ways, such as through appraisal and personal and professional development planning.
133. Further we consider that there is an important issue about choice of mentorship arrangements. At present there is little choice; doctors either engage in their local scheme (often trust-based) or not at all. We would welcome greater choice, which may reflect the differences in need, say between organisational, professional and specialty development and addressing performance problems.

#### Issues for further inquiry

134. Based on the above considerations, we suggest it would be helpful to gather information about:
  - experiences of closer integration of new consultant/GP programmes and arrangements for mentorship.
  - the full range of support processes available to, and used by, UK doctors at different career stages.

#### Why don’t we prepare mentees?

135. It is hard to believe that doctors cannot be helped to prepare for the role of mentee, rather than going into it ‘cold’. Some guidance is given in the literature about the areas for attention.
136. The programmes and schemes in the UK that involve practising the roles of mentor, mentee and observer go part way to addressing mentee preparation. The co-mentoring schemes in which doctors share the roles of mentor and mentee in the same session ‘for real’, each taking it in turn to speak and listen, take this even further.
137. But apart from this, so far we have found little evidence that career grade doctor-mentees are helped to make the best of mentorship opportunities offered, apart from any experience that they may have had of mentors as undergraduates or doctors in training. They are not, as far as we know, helped to develop mentor seeking skills which may assist them find informal mentors for themselves. Given that they are all

highly qualified and successful adults, this lack of preparation seems to be unsatisfactory.

138. There may be some lessons to learn from the appraisal process where appraisees find the process more helpful if they are given the opportunity to learn what is involved and what is expected of them beforehand. Perhaps if mentorship ‘taster’ sessions were introduced into new consultant programmes this might also help prepare doctors for their role as mentees as well as finding out more about how doctors find support.
139. There is perhaps one important issue for further consideration; how the purpose of mentoring and how it is provided changes as people progress through their medical careers. Appropriate mentoring for undergraduates may well be very different from that which will benefit senior doctors at times of transition. Further work on the different approaches at different career stages would be valuable.

#### Issues for further inquiry

140. Based on the above considerations, we suggest it would be helpful to gather information about:
  - mentee preparation and the impact this has on uptake, and the way that the schemes and relationships are conducted.

#### How formal should the role of mentor be?

141. Whereas there is no argument that doctors wanting to become a formal mentor in a designated scheme will benefit from preparation for the role, a number of questions are being asked. They include:
  - 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 them in their role, and, if so, how?
142. This inquiry did not seek and has not found clear-cut answers to these questions but perhaps some thoughts may be helpful. Intuitively, we might consider 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 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 perhaps a bit of ‘topping up.’
143. 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’ (‘you have to learn to sit on your hands’ as one contributor put it) 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. 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 to us). It is possible that the contrast between mentorship and clinical practice may be sharper in some specialties than others.

144. It is also the case that the practice of mentorship by doctors is not uniform. Some arrangements allow and encourage interactions that are fairly free and easy, albeit within ethical boundaries. The mentor and mentee may meet over a meal, the mentor may review the mentee's progress and knowledge of, say, local 'politics' and networks, and legitimately provides information and good 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, some might say rather austere, 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 it 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.
145. So the most appropriate form of mentor preparation and, we would argue mentee preparation, must depend very much on what is expected of the relationship and the interactions that give expression to it. It is not easy to define a way in which the effectiveness of various forms of mentor preparation can easily be compared as sufficient numbers of doctors are unlikely to experience more than one and even if they do, they will start to accumulate knowledge and expertise that would make baseline comparisons invalid. We suggest therefore that other approaches are needed to answer questions about mentor preparation. However, again intuitively, we would not expect mentors to be adequately prepared for the very varied issues that they may be asked to help with by a single educational event. Over time we would expect them to become more experienced and confident but 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 with mentor peers and facilitators and refresh their skills. 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.
146. As an extension to these issues colleagues are also discussing the professionalisation of the role of the 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?
147. Informal mentors are selected by others spontaneously and so these considerations are less easy to apply. Many doctors who have put themselves forward for formal development programmes have self-selected. Scheme organisers have told us that they 'reserve the right' to recommend that a doctors who have completed a course

does 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. We are aware that medical directors exert some sort of control over who is put forward as a mentor and, of course, in schemes where mentors are allocated this control can be much more easily exercised.

148. There are many descriptions in the literature about the roles and responsibilities of mentors and again these are highly contextual though with many elements in common. Colleagues have recently created through a careful process a template for a competency based job description for mentors of GPs using the NHS knowledge and skills framework.<sup>12</sup>
149. . One of the advantages of this approach may be that it will define more clearly the characteristics and objectives of any particular mentorship scheme although it should not be assumed that mentorship arrangements will only differ between specialties or when they are targeted at particular groups of doctors. Nor can we assume that the practice of mentorship will necessarily comply with a ‘job description’ unless there is some form of assessment and/or supervision.
150. Notably the European Mentoring and Coaching Council’s code of ethics<sup>13</sup> states:  
The coach/mentor will... maintain a relationship with a suitably-qualified supervisor, who will regularly assess their competence and support their development.
151. We have little information on whether doctors as mentors need supervision, and, if so, how this might be achieved given the scarcity of financial and time resources and the intrinsically confidential nature of the interactions with, commonly, a lack of any formal output. Mentoring arrangements 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 rather indirect form of supervision.
152. The issue of payment to mentors, either direct payment in the form of a fee or indirect payment in the form of allocated time within a job plan, is relevant here. ‘Payment’ implies an agreement to carry out a task or role and accountability for performance to a given standard. Not having any way of monitoring that performance does not seem to be consistent. We have very little evidence, however, that the performance of mentors is monitored, except through feedback from mentees at the end of their relationship with the mentor. Even this is only easily 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 not working well could be complex.
153. Contributors have told us that they were attracted to becoming a mentor, often as a natural progression from other educational roles or because of having been through a comparable experience themselves and wanting to help ease the path of others. Formalising the role of mentor may lead to its incorporation into arrangements for professional development and career advancement backed by appropriate financial or other remuneration, such as educational ‘credits’. Setting the professional role of

mentor alongside that of educational supervisor or appraiser may well help this process gather momentum.

154. Despite the arguments in favour of formalisation, deep down, we have reservations. Almost all current interest and activity in mentorship for doctors is concerned with formal arrangements. We know too that informal mentoring is often associated negatively in some people's minds with difficult power relationships, gender issues, abusive behaviour and patronage. But we would not want informal, 'spontaneous' mentorship to become a thing of the past. Formal mentorship as practised in UK medicine has developed its own ethos and recognised skills but nevertheless it is partly based on a natural human instinct, particularly prevalent among doctors – that of wanting to help others. Our concern stems in part from the possible compartmentalisation of professional behaviour – as extreme as 'I can't listen to you, unless I have been on the course, got the certificate and we have agreed the ground rules and limits of my responsibility, etc., etc'. It stems also in part from a distrust of a systems approach to bringing about cultural change. Systems have their place but it is a limited one. We distrust the view that progress is achieved through a few people having some good ideas and turning them into a system which everyone else can, and possibly, is expected to use. Owning personally the principles and values that underpin mentoring is crucial to its success.
155. Further, if members of an organisation know and trust each other, celebrate each other's excitement and success, share openly uncertainties and vulnerabilities and look on their work environment as a secure place for professional (and personal) exploration and development, then we wonder what place formal mentorship really has. If these qualities are not in place at work, we know that having a private listening relationship will help doctors cope better but it is not the whole answer. In moves towards greater formalisation of the roles of 'Mentors' we would urge that the wider approach of bringing mentorship principles into everyday professional life and relationships should also be nurtured.

#### Issues for further inquiry

156. Based on the above considerations, we suggest it would be helpful to gather information about:
- the formalisation of the role of mentors – reasons, approaches, benefits, costs and penalties
  - whether the wider availability of formal mentors has demonstrable benefits outside helping the individual doctor-mentees
  - how mentorship principles and values can be helped to have a wider impact outside the one-to-one relationships.

#### How are mentors and mentees best matched?

157. 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 claim to allow both participants to decline the other though how easy this is in practice is unclear. Some schemes require an initial meeting and then a decision is taken whether to continue. 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 very well for some but not all.

158. 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 other deliberately avoid this. 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. Senior doctors taking on new management roles may be offered a mentor from outside the employing organisation or indeed from outside medicine.
159. The literature gives a rather mixed picture about the importance of gender and ethnic origin. 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.
160. Some mentor development programmes employ personality measures (e.g. the Myers-Briggs Inventory). These are not used to match individuals (mentees do not usually participate) 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. It is not evident that this has been much used in mentoring schemes for doctors.
161. 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'. It is not easy to make sense of all this. Perhaps again, there are many issues at play:
  - the objectives and style of the scheme
  - the perceived characteristics of the target group
  - the size of the available mentor pool
  - the pressure on scheme organisers to demonstrate (numerical) success
  - the culture in which the scheme operates.

#### Issues for further inquiry

162. Based on the above considerations, we suggest it would be helpful to gather more information about:
  - mentor-mentee matching in different circumstances
  - how mentor and mentee preferences are taken into account
  - other factors, based on experience of mentoring for UK doctors as well as an appreciation of the literature from occupational psychology, that affect the mentor-mentee relationship.

#### How do we justify the costs?

163. The costs of mentor development are not negligible though in comparison to the benefits, they may be small. As one contributor, a course tutor, told us:

I really do think it does have a very powerful effect in organisations that's wholly beneficial. .... For around the £400 or £500 mark per participant I think you gain hugely in terms of accelerated learning, not just for the mentee but for the mentor as well.

164. Further justification comes, we believe, from the fact that doctors are acquiring new skills that may well affect the way that they work beyond the one-to-one 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 between colleagues.
165. Apart from initial mentor development costs (course tutors, venue etc) there are, of course, other costs associated with running schemes including:
  - Organiser's and administrator's time
  - Mentor's time and opportunity costs
  - Mentee's time and opportunity costs
  - Mentor support costs
166. Contributors made special reference to the need to ensure that continuing funding is in place as it takes at least two years to establish a scheme. They requested that information on sources of funding be shared.

#### Issues for further inquiry

167. Based on the above considerations, we suggest it would be helpful to gather information about:
  - costs of mentorship for doctors
  - sources of funding that have been deployed.

# Annex 1: About the authors and contributors

## Bill Fleming and Lesley Golding

Bill Fleming and Lesley Golding have backgrounds in psychology, education and educational research and development. They have worked in the compulsory education sector and in higher education. For the past 14 years they have been involved, as independent researchers and developers, in a range of projects concerned with professional and educational development in undergraduate and postgraduate medicine and dentistry, and patient and public involvement in healthcare.

Bill and Lesley have a particular interest in qualitative approaches to understanding educational and developmental issues which arise in professional practice. Their involvement in mentoring is part of their broader interest in how professionals learn and develop in, from and through practice and how practice communities and educational provision afford opportunities for different kinds of engagement in, or disengagement from, practice which may enhance or inhibit learning and development.

Bill Fleming and Lesley Golding can be contacted at [mail@soundingsresearch.co.uk](mailto:mail@soundingsresearch.co.uk)

## Jacqueline Gay

Jacqueline Gay trained as a secretary and has had forty years experience as a secretary and then a medical secretary. From 1982 she was a senior medical secretary at the United Bristol Healthcare Trust.

## Jolyon Oxley

Jolyon Oxley qualified as a doctor in 1971 and trained in neurology and clinical pharmacology. He became medical director of the National Society for Epilepsy and hon. consultant at the National Hospital for Neurology and Neurosurgery in 1979. After a brief period in medical publishing, he became secretary of the Standing Committee for Postgraduate Medical and Dental Education (SCOPME) in 1990 which produced influential documents among which were reports on appraisal, continuing professional development, mentoring and the need for a process of review for all doctors. He also became hon. secretary of the National Counselling Service for Sick Doctors (NCSSD) at this time.

After SCOPME was wound up in 1999, Jolyon became the first executive secretary of the Academy of Medical Sciences and in 2000 turned to working freelance in the area of doctors' professional development, currently concentrating on mentoring as part of the Department of Health's Improving Working Lives initiative and as adviser to the Academy of Medical Sciences' mentoring scheme for clinician scientists. Jolyon is also co-chair of the Gay and Lesbian Association of Doctors and Dentists (GLADD), a member of the BMA Board of Medical Education and a Trustee of the Epilepsy Research Foundation.

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## Helen Pask

After 20 years as a research biochemist, Helen Pask became a research administrator firstly at the Medical Research Council Head Office and then at the Royal Society. At the Royal Society, she had a key role in promoting women in science, engineering and technology. Part of this role was to oversee the mentoring scheme for the Royal Society's Dorothy Hodgkin research fellows (90 per cent of whom are women). This fellowship scheme is aimed at scientists who are at an early career stage and offers a recognised step to becoming an independent researcher.

The mentoring scheme focuses on personal and professional development, including raising self-confidence, achieving independence through successful funding applications, career planning, work/life balance and networking opportunities. Helen was responsible (with others) for mentor selection, matching with mentees, mentor and mentee development courses and getting feedback from mentees and mentors on how the scheme was working or could be made even better.

## Alison Steven

Alison Steven works both in the Postgraduate Institute for Medicine and Dentistry and the School for Medical Education Development in the University of Newcastle, where she is involved in both research and teaching. In 2002 she graduated at PhD level having undertaken a study of clinical skills education for nurse practitioners which spanned areas of both nursing and medical education. Her interests lie in the philosophies which underpin educational research and her area of expertise lies in 'relativist' or qualitative approaches. Educational issues of interest include 'learning cultures', what influences the views and opinions of those involved in education, interprofessional education, and the implementation of schemes or programmes. Alison has been involved in a range of projects and is currently involved in an exploration of educational supervision in the Northern Deanery and the development and evaluation of 'The Newcastle Common Learning Project' funded by the Department of Health. Her involvement in the mentoring project is directly related to her interest in implementation and the 'cultural' aspects of education.

## Chloë Warrington

Born in Farnborough, Kent, Chloë spent her school years in Bromley and Croydon. She completed her honours degree in Applied and Human Biology at Aston University in 1997. Her time there included a 'placement year' during which she worked with a team of scientists sequencing haemagglutinin genes from 'flu strains isolated around the world, as part of the WHO vaccine effort.

After graduating, Chloë trained as a secretary and found roles in secretarial training and then recruitment. Following a two month trek of southern African countries in 1999, she worked within the corporate communications at Glaxo Wellcome in Stevenage and Greenford, coordinating a wide range of projects relating to science education. As a mature student she began the MBBS medical degree at Imperial College, London, in 2001 and hopes to qualify in 2006.

## Reinhard Wentz

Reinhard is a librarian and has a diploma in Academic Librarianship from Hannover University. He is a member of the library staff at Imperial College London, based at

the Chelsea & Westminster Campus. He has just returned from a two-year secondment to the Cochrane Injuries Group as their trial search co-ordinator. He has been involved in numerous systematic reviews on medical, social, and technical subjects, organized and facilitated a range of workshops on evidence-based health care, user training, patient information and related subjects. Reinhard can be contacted at [r.wentz@imperial.ac.uk](mailto:r.wentz@imperial.ac.uk)

## Annex 2: Suggested issues for further inquiry

Based on the considerations in Section 6, we suggest it would be helpful to gather information about:

- doctors who participate in schemes that do and do not target mentorship at particular groups of doctors, with particular reference to points b) to f) in paragraph 124.
- experiences of closer integration of new consultant/GP programmes and arrangements for mentorship.
- the full range of support processes available to, and used by, UK doctors at different career stages.
- mentee preparation and the impact this has on uptake, and the way that the schemes and relationships are conducted.
- the formalisation of the role of mentors – reasons, approaches, benefits, costs and penalties.
- whether the wider availability of formal mentors has demonstrable benefits outside helping the individual doctor-mentees.
- how mentorship principles and values can be helped to have a wider impact outside the one-to-one relationships.
- mentor-mentee matching in different circumstances.
- how mentor and mentee preferences are taken into account.
- other factors, based on experience of mentoring for UK doctors as well as an appreciation of the literature from occupational psychology, that affect the mentor-mentee relationship.
- costs of mentorship for doctors.
- sources of funding that have been deployed.

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