

Improving Working Lives for Doctors

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Mentoring for doctors: a look at the literature

A review of some of the UK and US literature on mentoring for doctors produced
on behalf of the Doctors' Forum by

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**Produced in conjunction with two other working papers - Mentoring for doctors:
enhancing the benefit and Mentoring for doctors: talking about the experience**

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Improving Working Lives for Doctors

The Doctors' Forum was established in February 2002 after delegates, at the first Improving Working Lives (IWL) for Doctors' Conference, identified the need for a group that could influence policy development in areas that matter most to doctors. The main function of the Doctors' Forum is to develop and take forward a range of initiatives they deem important to Improving Working Lives for Doctors. Offering staff a better deal in their working lives is essential if the NHS is to retain trained and experienced clinicians.

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

In addition to this document for consultation, the Forum has also produced *Welcome to the team* an introductory pack for junior doctors joining the NHS for the first time and *Becoming a Consultant* a collection of frequently asked questions for specialist registrars.

The Doctors' Forum website has been developed at www.doh.gov.uk/doctorsforum to improve communication between doctors and the Department of Health.

Authors' acknowledgements

We would like to express our admiration of all those who have shown inspiration, leadership and personal commitment to 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.

About this document

This report of the interviews conducted as part of this inquiry is one of three that have been produced for the Doctors' Forum on mentoring for doctors. The other two comprise *Mentoring for doctors: enhancing the benefit* which contain some recommendations and issues for further inquiry and *Mentoring for doctors: talking about the experience*, an analysis of the interviews carried out as part of this inquiry. They are available at <http://freespace.virgin.net/ncssd.org/Mentor1.pdf> and <http://freespace.virgin.net/ncssd.org/Mentor2.pdf>

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

Please note that the variable spelling of certain words in this document reflects their UK and USA origins.

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1. How this inquiry has been conducted

1. In 2002, the Doctors' Forum identified that mentoring may provide a useful support mechanism for doctors if it were more widely available.
2. In autumn 2002, a search was made for mentoring schemes for doctors, primarily in England. Details of over 50 schemes were collated and made available to respondents. The schemes involved general practice, hospital medicine and public health medicine. Some of the schemes are 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. A research protocol was agreed after consultation and external review. Multi-site research ethics committee approval was obtained.
5. An anonymised interview-based inquiry has been conducted across five mentoring sites in England involving over 30 interviewees. The analysis of the interviews is presented in the accompanying working paper *Mentoring for doctors: Talking about the experience*.

The literature search

6. In accordance with the inquiry protocol, and guided by two librarians, a strategy was devised to achieve a pragmatic, preliminary literature search that would illuminate and inform the project 'Establishing the parameters of current practice in mentorship schemes for doctors'. It was not intended to be a formal systematic review. The following strategy was adopted on the following databases and resource collections:
 - MEDLINE /PubMed
 - EMBASE
 - CINAHL
 - Cochrane (Cochrane CCTR)
 - Web of Science (incl. Science Citation Index, Social Science Citation Index and Humanities Citation Index)
 - ERIC
 - Infotrac
 - Elsevier Science Direct
 - Emerald Fulltext
 - Wiley Interscience
 - Bio Med Central
 - EBSCO
 - BIDS
7. The following outline search strategy (PubMed Notation) was used:
 - 1) 'mentors'[MAJR] or mentor* [ti]

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- 2) evaluation OR quality OR trial OR review OR outcome OR effective OR cohort OR case-control OR interviews OR questionnaire OR surveys OR ethnographic OR grounded theory or observational OR focus groups OR narrative OR cluster OR benefits
- 3) 1 and 2
- 4) student*[ti]
- 5) 3 not 4

with suitable variations (incl. truncations, additional keywords, spelling variations) on different databases and resource collections.

8. The search was designed to concentrate on specific mentoring studies and was not widened to include material on coaching, clinical supervision, tutoring, or preceptorship. It also concentrated on mentoring for doctors and health care professionals but did not ignore substantial evaluated studies on mentoring in other professions found during searching the databases as listed above. Material for mentoring schemes involving students was excluded.
9. The search concentrated on publications in English during the last ten years, primarily on journal articles, but included any books/excerpts from books that are incidentally retrieved during searches.
10. All references were delivered as lists of references with abstracts where available after importing into RefMan for de-duplication, production of bibliographies etc.
11. The lists of references were scanned by the author to identify studies for further inspection and analysis. Fulltext versions/photocopies of these studies were obtained. At the outset it was expected to find some 3000 studies as part of the literature searches with perhaps some 200 records requiring inspection of the full article.
12. A citation analysis of up to 30 selected articles was also undertaken on WoS and a list of possible additional studies was compiled and an analysis of some 20 studies (on Medline) using the 'see related' algorithm. It was not planned systematically and routinely to contact authors of core studies, analyse list of references or search the Internet for relevant sites.
13. The literature search was conducted during July and August 2003. Once the papers were retrieved, a written synopsis was made of each and this document is a summary of the main findings grouped under much the same headings as used in the accompanying working papers. The summary concentrates on papers published in peer reviewed journals. By and large books and documents produced by medical organisations etc. are not included.
14. In this limited review, an attempt has been made to stay as close to the published papers as possible and the findings are presented largely without comment. All the papers listed in the footnotes have been read for the purposes of this review. References mentioned in brackets in the text have been cited by the authors of these papers and have not been reviewed by the author.
15. The findings from the papers reviewed are presented from several different perspectives, following the approach adopted in the companion working papers. Inevitably, therefore, there is some repetition.

16. The author acknowledges fully the skills that the authors of the reviewed papers have shown. Deconstructing their skilfully crafted papers was not always easy but an attempt has been made in order to illustrate the main themes that have arisen from this inquiry. Undoubtedly this approach does not allow the reader to appreciate fully the richness of these authors' work and the many other themes and issues that they have discussed. To that extent, the only way to appreciate the literature is to read it for oneself. Nevertheless it is hoped that this working paper helps to provide some of the evidence on which recommendations for action and further inquiry can be soundly based.
17. Throughout this document, the UK and the US literature are considered separately because the contexts in which doctors from these countries learn, work and develop may be very different.

2. What do authors mean by mentoring?

18. In this section an attempt is made to answer this question below from the published literature with particular reference to:
 - a) What are the key concepts and definitions?
 - b) Does mentoring have the same meaning for everyone?
 - c) Does it have a particular meaning for doctors and UK doctors in particular?
 - d) Are there different types of mentoring?
 - e) How does mentoring sit alongside other processes?

UK literature

19. Definitions, and perhaps more usefully, descriptions of mentoring are rather differently drawn in the UK literature compared to the US literature. In a glossary of educational terms, Pitts and Percy¹ (citing Carmin, C.N. Issues on research in mentoring: definitional and methodological. *International Journal of Mentoring* 1988;2:9-13) state that mentoring

is a complex, interactive process occurring between individuals of differing levels of experience and expertise which incorporates interpersonal or psychosocial development, career and/or educational development and socialisation functions into the relationship. This one-to-one relationship is itself developmental and proceeds through a series of stages which help to determine both the conditions affecting and the outcomes of the process to the extent that the parameters of mutuality and compatibility exist in a relationship, the potential outcomes of respect, professionalism, collegiality and role fulfilment will result. Further, the mentoring process occurs in a dynamic relationship within a given milieu.

20. In its 1998 report, the Standing Committee on Postgraduate Medical and Dental Education (SCOPME)², an advisory body to the Secretary of State for Health, adopted the following description of mentoring that is widely cited in the UK literature.

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, or talking in confidence to the mentee.

21. With their background in helping doctors from overseas to settle in the UK, Gupta and Lingam³ describe mentoring as

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.

22. The authors also stress that mentoring is about change,

¹ Pitts J, Percy D. A glossary of educational terms. *Education for General Practice* 1997;8:140-143.

² Standing Committee on Postgraduate Medical and Dental Education. *Supporting doctors and dentists at work: an inquiry into mentoring*. London: SCOPME, 1998.

³ Gupta RC, Lingam S. *Mentoring for doctors and dentists*. Oxford: Blackwell Science, 2000

See also: Lingam S, Gupta R. *Mentoring for overseas doctors*. *BMJ* 1998;371:S2

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- both responding to change in the environment and promoting change in the mentee. The basis of change is a new vision of possibilities.
23. They further describe mentoring as a function carried out within the context of an ongoing supportive relationship, being confidential, non-judgemental and entirely voluntary. But they add
- There is no blueprint for ideal mentoring, it can be a one off intervention or a long relationship, part of an existing friendship or formal and highly structured.
24. Echoing the transfer of benefit from mentor to mentee, Roberts and colleagues from the standpoint of psychiatry state⁴ that mentoring is
- the offer of a confidential, professional and supportive relationship, by an experienced colleague, able and willing to share his or her knowledge and experience to a protégé or mentee.
25. However they also emphasise that this is not about the transfer of knowledge alone: mentorship is based on a continued emphasis on the 'the person' of the doctor alongside the acquisition and maintenance of knowledge and skills.
26. The UK literature from general practice in east Anglia on the whole emphasises the mutuality of the mentoring relationship, Alliott⁵ describing it as
- a dialogue between two autonomous practitioners on a voluntary basis.
27. This author summarises the essence of mentoring as follows:
- Mentoring in general practice facilitates personal/professional development looking at both education and pastoral issues as a mentee's agenda dictates
 - Mentoring necessitates the development of a caring and trusting relationship.
 - Mentoring helps mentees understand their true thoughts and needs.
 - Mentoring encourages constructive reflection before exploring alternative courses of action.
 - Mentoring in general practice is voluntary between autonomous principals.
28. Bregazzi and colleagues⁶ from general practice in County Durham state:
- Mentoring can be characterized by the nature of the relationship that it describes, one of trust and compatibility between a senior who does not control and a junior who is not subordinate, in which the particular arrangements are freely agreed. This relationship differs from that between trainees and their vocational trainer, who contributes among other things to the summative assessment of trainees for purposes of certification.
29. Connor and colleagues⁷, reporting their experiences from a postgraduate deanery perspective in the north of England, state simply
- learning and development will take place if there is an appropriate balance of support and challenge.

⁴ Roberts G, Moore B, Coles C. Mentoring for newly appointed consultant psychiatrists. *Psychiatric Bulletin* 2002;26:106-109

⁵ Alliott R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

⁶ Bregazzi R, Harrison J, van Zwanenberg T. Mentoring new GPs: experiences from GP Career Start in County Durham. *Education for General Practice* 2000;11:58-64

⁷ Connor MP, Bynoe AG, Redfern N, Pokora J, Clarke J. Developing senior doctors as mentors: a form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors. *Med Educ* 2000;34:747-753

and

The essence of mentoring is that of a learning relationship.

Confusion over terminology

30. Several authors point to the lack of an agreed concept in the term ‘mentoring’. From a general practice perspective Challis and colleagues⁸ point to the range of meanings of mentoring, often relating to a range of other roles such as teacher, encourager, counsellor, facilitator, supporter, coach and confidant and these roles are often seen as changing within the relationship as the learning develops. Similarly, Eastaugh and colleagues from east Anglia state⁹
Models of mentoring vary widely. Mentors may be powerful, supportive and senior father figures on the one hand or suppliers of empathy and non-judgmental acceptance on the other.
31. While discussing arrangements for mentoring senior house officers in accident and emergency medicine Okereke¹⁰ states that there is
no clear understanding ... in modern medicine or industry of what constitutes mentoring and how it can tangibly benefit a particular workforce. There is no clear definition in the literature on how employing organisations may benefit; however, there is evidence that mentoring may specifically aid learning.
32. In 2000 Bregazzi and colleagues¹¹ concluded
The practice of mentoring is shrouded in some confusion, both in the field and in the general practice literature, yet it could be a useful mechanism to support the transition of young GPs from registrar to established principal.
33. The tendency to use the term ‘mentoring’ rather loosely has been challenged by Freeman¹² as follows:
[concerns were expressed over] the growing tendency to use the title ‘mentor’ to cover a wide variety of activities, thus creating confusion and threatening the ability of doctors to make accurate choices about the type of support they might need in facing the professional challenges of the next decade.
34. That Freeman’s view is still relevant can be seen by looking at the many references to ‘mentors’ and ‘mentoring’ in the papers on the *British Medical Journal Careers* website and in other papers where mentoring is mentioned almost as a necessary embellishment. Although authors always advocate mentoring, very few give any description of what they mean by the terms or what the implications are for providing mentors. Often the term ‘mentor’ or ‘mentoring’ appears in a bullet list or table without further explanation.

⁸ Challis M, Mathers NJ, Howe AC, Field NJ. Portfolio based learning: continuing medical education for general practitioners – a mid-point evaluation. *Med Educ* 1997;31:22-26

⁹ Eastaugh A, Barnett M, Parlby S, Paxton P, Sackin P. Co-tutoring: peer-supported learning. *Education for General Practice* 1998;9:517-519

¹⁰ Okereke CD. Mentoring – the trainee’s perspective. *J Accd Emerg Med* 2000;17:133-135

¹¹ Bregazzi R, Harrison, J and van Zwanenberg T. Mentoring new GPs: experiences from GP Career Start in County Durham. *Education for General Practice* 2000;11:58-64

¹² Freeman R. Faculty mentoring programmes. *Med Educ* 2000;34:507-508

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How mentoring sits alongside other processes

35. The role of mentoring as an aid to GP continuing education and professional development has been championed in general practice for some years. The main elements are set out in the 1993 RCGP occasional paper¹³ in which the role of the mentor is described as
valuable in helping to identify learning activities, and how learning can be demonstrated, in clarifying learning needs, and in offering support and challenges to the learner.
36. As well as advocating the role of the single mentor, the paper also presents models of co-mentoring and small group mentoring.
37. Pietroni¹⁴, who was the convenor of the RCGP working group that produced this occasional paper, shows the link between portfolio learning and mentoring, suggesting they are approaches that will strengthen reflection on practice.
Portfolio based learning recognises the importance of reflection in learning, and the mentor provides appropriate learning support. These important concepts play an essential part in facilitating reflection by the process of debriefing (with a mentor) and keeping a diary or a log (a portfolio).
38. The literature shows how the original concept of mentoring in which a designated mentor (a GP peer with experience in GP education) mentors helps other GPs to develop their educational plans, developed into a co-mentoring model. Under these arrangements, one GP mentors another and then the roles are reversed in the same session, a process called co-tutoring (also known as co-mentoring). This development allowed the matters being discussed to be widened from the core purpose of assisting with engagement in continuing education.
39. Co-tutoring is distinguished from another process, called co-counselling, by Sackin and colleagues¹⁵ as follows:
co-tutoring differs from co-counselling in that it puts the emphasis on forward planning and feedback skills, allowing understanding and insight towards self-development. It also aims to facilitate self-development in others, raising awareness of emotional blocks and how they can get in the way. Co-counselling, on the other hand, is a therapeutic process focussing on the release of emotion with self-development and insight being an outcome of the process.
Both processes are based on the assumption that people are not listened to well enough in their lives and that, if they were listened to better, they would flourish.
40. A key factor that distinguishes mentoring from other processes is the lack of any 'report back' function which Freeman¹⁶ describes as
a critical factor in the mentee's ability to confront problems relating to organisational and clinical management and to work confidently towards achieving positive and effective change. All 65 mentees who were questioned

¹³ RCGP Working Group on Higher Professional Education. Portfolio-based Learning in General Practice. London: Royal College of General Practitioners, 1993

¹⁴ Pietroni R, Palmer A. Portfolio based learning and the role of mentors. *Education for General Practice* 1995;6:111-114

¹⁵ Sackin P, Barnett M, Eastaugh A, Paxton P. Peer supported learning. *British Journal of General Practice* 1997;47:67-68

¹⁶ Freeman R. Information shared in mentoring must remain confidential. *BMJ (letter)* 1997;314:149

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attached appreciable value to the absolute confidentiality of their discussions with their mentor.

41. Although the focus of this working paper is not on mentoring for undergraduates, it is worth noting that in an editorial reviewing a paper about undergraduate mentoring in Switzerland, the same author¹⁷ describes faculty mentoring (as practised in the USA) as being akin to the UK personal tutoring system.

Students participating in a degree programme are assigned an individual tutor who is a member of the academic team managing the teaching and delivery of the programme.

42. She suggests that the tutor's task is to assist the student achieve both the course objectives and their personal objectives. However, in the personal tutoring system the tutor will have a role in the assessment of the student. Freeman suggests this

sits uneasily with mentoring, where the mentor's neutrality and objectivity have been seen by the recipients of mentoring as an important factor in the effectiveness of the relationship, and the inclusion of any assessment function as a potential handicap.

43. Okereke¹⁸, writing from a hospital perspective, suggests that mentoring can complement the system of assessment and appraisal as it remains the only informal means of identifying deficiencies in training and effecting changes with minimal stress to the trainee. He concludes

a good scheme with adequately trained mentors should recognise the need to separate mentoring from appraisals and assessments. It should help mentees recognise their abilities and limitations. Finally, good mentoring will lead to excellent appraisals and subsequently excellent assessments. Therefore, a lot of responsibility lies on the shoulders of the mentor.

44. In a commentary which reviews three of the processes in which hospital doctors participate (assessment of performance, contract review and professional review) Bulstrode and Hunt¹⁹ distinguish the needs of three stakeholder: the regulators of health care, the local employer and

The third stakeholders are the specialists themselves. Our work with many thousands of these individuals suggests that they want a regular meeting with a person they trust and respect, at which they can discuss in confidence all aspects of their professional life. This meeting should be reflective not judgmental, and would not involve negotiation, although it should result in an agreed report. Of the three, this relationship probably comes closest to Mentor's with Telemachus, that of the respected friend whose first duty was to help and advise his absent friend's son. It could perhaps be called mentoring. Even so, the word mentor has so many other connotations that this meeting is probably more appropriately called a "professional review".

Although each of the meetings described above performs an important function, it is in their synergy that their real value appears. For the majority of doctors, whose performance is satisfactory, the professional review is valuable in encouraging the individual to reflect carefully on his or her needs before entering into a contract review with the employer. However, if at assessment a specialist's standard of practice is found to be unacceptable, the "contract" needs to be checked in case the job is making unreasonable demands on the individual. The

¹⁷ Freeman R. Faculty mentoring programmes. *Med Educ* 2000;34:507-8

¹⁸ Okereke CD. Mentoring – the trainee's perspective. *J Accd Emerg Med* 2000;17:133-135

¹⁹ Bulstrode C, Hunt V. What is mentoring? *Lancet* 2000;356:1788

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agreed report from the professional review will then show whether the individual has insight into any of the problems. If not, retraining will be unlikely to salvage the situation.

45. **The authors warn**

A meeting that tries to blend the functions of all three of these, whatever it is called, cannot work. Mentoring may be the soft word used to foist just such a useless compromise on a paranoid profession. Mentor, himself, would turn in his Ithacan grave.

46. **Roberts and colleagues²⁰ suggest that mentoring differs from the more technical processes around clinical governance and that it can offer a confidential context in which processes such as personal development plans [PDPs] and revalidation can be anticipated and used to maximum advantage. Mentoring, they suggest, is**

different from PDPs, appraisal and approval but is complementary and supportive of them.

47. **Bligh comments**

how much and what type of support doctors need at different stages of their careers, how this should be provided and by whom, are as important as those questions concerning the statutory measures required to demonstrate continuing competence.

USA literature

48. **In a 1993 paper, two authors in radiology describe mentoring as**

one of the most intense, psychologically and emotionally charged professional relationships an individual can experience. A simple definition of a mentor is a person with higher career status who, by mutual consent, takes active interest in the career of a junior colleague.

49. **Much of the literature on mentoring for doctors in the USA centres on the needs of younger doctors in academic departments. Two papers quoting other authorities give the follow similar descriptions.**

a reciprocal relationship between an advanced career incumbent (the mentor) and a junior faculty member (the protégé) aimed at fostering the development of the junior person/protégé.²¹

Mentoring is a dynamic reciprocal relationship in a work environment between two individuals where, often but not always, one is an advanced career incumbent and the other is a less experienced person. The relationship is aimed at fostering the development of the less experienced person.²²

50. **The fact that mentoring is a relationship, rather than just a set of activities is emphasised by many US authors. A statement from JA Barondess, the President of the New York Academy of Medicine illustrates this²³. Mentoring is**

a multi-faceted and complex relationship between senior and junior professionals which, when successful, serves to fortify and extend within the younger person characteristics and qualities integral to professional development. Thus,

²⁰ Roberts G, Moore B, Coles C. Mentoring for newly appointed consultant psychiatrists. *Psychiatric Bulletin* 2002;26:106-109

²¹ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. 'Having the right chemistry': a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

²² Bauchner H. Mentoring clinical researchers. *Arch Dis Child* 2002;86:82-4

²³ Barondess JA. On mentoring. *J R Soc Med* 1997;90:347-349

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mentoring enables younger colleagues to learn about the environment they are entering, including its priorities, its customs and usages and the identities of the leading figures, institutions and structures. Further, in the academic enterprise in medicine, mentoring is especially important in the shaping of an academic *persona* and in the formulation and implementation of a career trajectory.

51. **The role of mentoring in learning to be a doctor is explained by another author thus²⁴:**

Mentoring is teaching and providing the opportunity to learn, but should involve more. It should involve the motivation to excel. We are fortunate in that our jobs involve working with good people using the latest technology in advanced centers. We must never forget, however, that nothing can take the place of direct personal experience with the patient in the clinical setting. How the student interprets that experience can be largely influenced by their mentor.

52. **Sachdeva²⁵, a professor of surgery, reiterates the personal and professional aspects and points to how the relationship may develop and change over time.**

Mentoring involves an intense, global, and long term relationship between a mentor and a protégé/e, and encompasses both professional and personal domains. It spans several years and may extend far beyond the period of the structured mentorship.

53. **He further distinguishes mentorship from preceptorship suggesting that both mentorship and preceptorship are frequently found in teaching programmes but there is little consistency in their use, with the terms being used interchangeably and a variety of role modelling and preceptorial activities loosely included under the general umbrella of mentorship. The preceptorial relationship is especially effective in bridging the theory – practice gap and enhancing the hands-on skills of students. Mentoring involves a longer and more intense relationship and results in significant impact on both parties.**

54. **Another surgeon Souba²⁶ draws distinctions between an older model of mentoring which was characterised by a paternalistic, authoritarian, strict approach to raising the ‘mentoree’ and the new approach described by the author as involving empowering, partnership, inspiring, liberating and developing in the mentoree.**

a worthy mentoring relationship is infrequently short-term – it takes time to develop. Similarly, the majority of exceptional mentoring relationships are, with time, relatively informal. Mentors have resources (time, energy, power, knowledge, experience, access to the political battlefields, physical assets) – to the extent that they share them tells us something about the degree to which they value the mentoree’s development. Mentoring can be defined as a fundamental and vitally important form of human development where one person invests time, energy, and personal know-how in helping another person grow and improve to become the best that he/she can become.

55. **The author distinguishes between the role of faculty adviser and mentoring.**

An adviser’s job is to offer advice and provide counsel – the dialogue between the adviser and the resident is often unidirectional and perhaps more formal. The

²⁴ Benjamin JB. Mentoring and the art of medicine. *J. Trauma, Injury, Infection and Critical Care* 1998;45:857-861

²⁵ Sachdeva AK. Preceptorship, mentorship and the adult learner in medical and health sciences education. *J Cancer Educ* 1996;11:131-136

²⁶ Souba WW. Mentoring young academic surgeons, our most precious asset. *J Surg Res* 1999;82:113-120

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interchange may occur only once – the resident does not necessarily view the adviser as a role model. Mentoring, conversely, involves a personal as well as a professional relationship, one that develops and grows over an extended period of time – the mentor is invariably an important role model for the mentoree. Mentors are people we look up to; they are those individuals we emulate and want to be like. They embody many of the qualities we most admire and would like to possess ourselves.

The older view of mentors as paternalistic, authoritarian, strict and protective has shifted to one that looks upon mentors as empowering, inspiring, and liberating. Similarly, the traditional view of the mentoree as a subservient favourite son has changed to one that views the mentoree as a responsible equal whose job it is to acquire, over time, independence and self assurance.

56. The author then describes in more detail the ‘many hats’ that the mentor may adopt. These include (1) adviser/counsellor/consultant, (2) friend, (3) agent, (4) teacher/helper, (5) coach, (6) manager and leader. The author offers a list of what mentors do: they Motivate, Empower and Encourage, Nurture self confidence, Teach by example, Offer wise counsel, Raise the performance bar, Shine in reflected light.
57. Another paper²⁷ attempts to separate the terms often used in the same context. They suggest that the term ‘mentor’ connotes a different position from those of other types of teachers such as preceptor, supervisor, role model and tutor. The preceptor is focussed on teaching and learning, whereas a mentor seeks a closer and more personal relationship.
58. Preceptorship has been described as more formal, shorter and more structured than mentorship. The term supervisor is used interchangeably with mentor but the authors state that supervision implies critical watching and directing without the warmth implied by the term mentoring. Tutoring may be one of the duties that a mentor performs which a more restrictive term. Any of these activities may co-exist and the same person can act in more than one capacity.
59. These authors conclude:

if one understands mentoring as a partnership, it is easy to see that a natural course may be one in which the person mentored develops confidence and independence so that the role of the mentor-teacher evolves from authority to guide to, finally, colleague and companion.
60. Many US authors give detailed accounts of people who provided them with leadership and support and some mention them by name.

They, too, saw mentoring as an opportunity to help an inexperienced physician grow, as well as a professional *obligation* that would benefit both me and themselves.²⁸

and

Great mentors hope their trainees will do better than they have done – they want them to exceed their expectations, soar to new heights, and set new records. In this process, they want their mentorees to learn to be unassuming. Modesty is a universal quality of outstanding mentors.²⁹

²⁷ Bhagia J, Tinsley JA. The mentoring partnership. *Mayo Clin Proc* 2000;75:535-537

²⁸ Setness PA. Mentoring. *Postgrad Med.* 1996;100:15-22

²⁹ Souba WW. Mentoring young academic surgeons, our most precious asset. *J.Surg Res* 1999;82:113-120

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61. Almost seeming to recall a bygone age, Richardson³⁰, an academic surgeon from Louisville, Kentucky states

Students were afforded tremendous opportunities in those days ... We had a tremendous amount of direct contact with the senior faculty, both in the laboratory and on the wards.

The other attribute of my mentors that they seemed to be having such fun (or at least great enjoyment from their work). In retrospect, what those mentors offered, above all else, was a sense of excitement about the profession. We were doing great things: conquering coronary artery disease, advancing liver transplantation and finding a new method of resuscitation that would save millions of lives. My mentors of that era were often bold, innovative dreamers who dared to think big in a country that seemed to prize medical innovation and research and to value improvements in patient care.

On reflection, finding enjoyment in one's work is the most important message a mentor can convey.

62. The author reflects on the various career opportunities he was afforded in different posts.

while prudence is often laudatory and nearly everyone now feels compelled to have a carefully worded contract or letter of appointment, such legalities are anathema in many ways to a true mentor – tyro relationship. If mentors are not inherently supportive, then 'having it in writing' offers little consolation.

As we collectively whine about managed care, Dean's taxes, unfair hospital administrators, declining reimbursement, and the necessity for academic surgeons to be 'cash cows' and fret over burn out, can we generate and convey the enthusiasm needed to be good mentors and attract brilliant students and residents to our way of life? Dream great and important dreams, build something lasting that will influence generations of surgeon to come, provide an opportunity to be all you can be, and have fun. These are the lessons I have learned from my mentors.

63. In a Presidential Address for the Society of Gynecological Surgeons, Weinstein³¹ mentions many of the people who mentored him and whom he has mentored. He ends by quoting Gabbe (Gabbe SG. The alphabet of academic medicine. *Obstet Gynecol.* 1996; 88:479-481) as saying

mentor: pick a good one, be a good one.

64. Hollingsworth, a cardiologist, suggests³² that some teachers can be mentors without the learner understanding at the time what they were about. Mentoring

goes far beyond imparting information; that's what teachers are expected to do. Passing on wisdom, now that's quite another matter.

and

An interesting characteristic of my mentors, beyond the respect in which I held them, is that they were unaware they were changing me in subtle ways. It was happening in an atmosphere where the primary purpose was the passing on of information, but something about them allowed me to grasp more than they were saying.

³⁰ Richardson JD. On mentoring. *Arch Surg* 2000;135:1369-1370

³¹ Weinstein SA. A mentoring society. *Amer J Obstet Gynecol* 2001;185:1294-1298

³² Hollingsworth JH. The difference between a mentor and a teacher. *Am J Cardiol* 2002;89:1004-1005

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65. Many of the US papers refer to ‘faculty mentoring’ as a method of helping young doctors in academic medicine. Schapira and colleagues³³ in a 1992 paper from general internal medicine highlights the teaching role of the mentor in particular suggesting that feedback on research ideas, one-to-one didactic sessions and advice on important reading and course work are all important. They suggest that a mentor may advise a protégé to attend a particular conference, to join a specific committee and also exercise a sponsorship role on behalf of the protégé to promote the protégé’s career, for example suggesting that the protégé participate in a workshop.
66. Finally, the authors suggest that the mentor may aid in the socialisation of the protégé into the profession by conveying appropriate social protocols, etc. They also suggest that the protégé may contribute significantly to the research agenda of the mentor, either directly or by providing a stimulating source of interaction.
67. Anderson³⁴, a professor of dermatology, in considering mentoring particularly for medical students, suggests that the meaning of being a mentor has been diluted by our concerns to ensure the widest opportunity to the largest number of young people. The author suggests that many of the activities that go under the label of mentoring are more about ‘guidance counseling’. True mentoring, the author suggests, involves a vastly greater effort, sustained for years, even decades, with a much more elaborate commitment.

there is something of the parent-child relationship, sustained for years with an authentic loyalty and appreciation each for the other. Career concerns are at the core of the relationship, and success is very sweet to both.

68. The author suggests that using this definition, true mentor relationships are not common but are exclusive and valuable. He suggests that a class of students can find guidance, academic help, role models, and career advice but most will not find mentors.

In summary, mentor – protégé relationships are highly valuable and exceptional – and are not available to everyone. Mentors are not summoned forth by a few rallying calls at faculty meetings; true mentors are exceptional people with unusual talents. Real mentoring will remain an extraordinary privilege.

69. Nevertheless the USA literature is strong on the need for mentoring of young doctors in academic departments.

mentoring is a commonly recommended strategy to promote the socialisation, development and maturation of academic medicine faculty.³⁵

and

mentoring is arguably one of the most important and least understood functions of academic pediatric departments... High quality mentoring, the process by which role models counsel and guide trainees, is integral to the success of all training endeavours.³⁶

³³ Schapira MM, Kalet A, Schwartz MD, Gerrity MS. Mentorship in general internal medicine: investment in our future. *J Gen Intern Med* 1992;7:248-251

³⁴ Anderson PC. Mentoring. *Acad Med* 1999;74:4-5

³⁵ Bower DJ, Diehr S, Morzinski JA, Simpson DE. Support-challenge-vision: a model for faculty mentoring. *Medical Teacher* 1998;20:595-597

³⁶ Drotar D, and Avner ED. Critical choices in mentoring the next generation of academic pediatricians: nine circles of hell or salvation? *J Pediatr* 2003;142:1-2

70. Barondess distinguishes the powerful explicit and implicit elements in mentoring. Explicit processes involve the active transmission of facts, techniques and systems of thought, through overt and deliberate processes in which the mentor ‘acts in teacher, adviser and sponsor roles.’ Implicit processes are not consciously or deliberately displayed and involve the exemplar rather than the mentor. Within this is included the Samaritan functions of the physician
- those elements of support, empathy and identification with the suffering of patients that characterise doctoring at its best.
71. This author further distinguishes mentoring from role modelling. The former is an ongoing process over time in which there is an active interpersonal, purposeful interaction. Role modelling is not necessarily interactive and a number of role models may impact on large numbers of individuals whereas mentors ordinarily have relationships with only a few. Characteristics of physicians identified as good role models are explored further in a paper by Wright and colleagues³⁷.
72. Mentoring relationships were characterised in a 1997 paper by Galicia and colleagues³⁸. They suggest that (1) mentorships are helpful relationships usually focussed on achievement, (2) Whereas the specific functions provided to protégés by mentors vary, mentoring includes any or all of the following three broad components: emotional and psychological support; direct assistance with career and professional development; and role modelling. (3) Mentorships are reciprocal relationships. (4) Mentorships relationships are personal. (5) Relative to their protégés, mentors show greater experience, influence and achievement within a particular organisation or environment.
73. Souba³⁹ coins the term ‘purposeful mentoring’ as a process designed to enhance the growth (and, implicitly, the performance) of those individuals being mentored. He suggests that developing a set of skills which can be monitored results in improvement for the whole faculty. He also suggests that the components of purposeful mentoring are the development of knowledge and performance skills. He gives examples from the laboratory and also suggests that it is important for the young surgical trainee to be able to distinguish between knowing how things are done and why things are done. The next element of purposeful mentoring is the building of interpersonal skills – the ability of people to work together in teams suggesting
- regardless of how capable or knowledgeable an individual is about a particular field, the inability to work well with others is almost always a fatal flaw.
74. Linney⁴⁰, Director of Career Development at the American College of Physician Executives, Tampa, Florida, questions whether the term ‘mentor’ is useful at all.
- physician executives who have advanced in their careers have had people who helped them. Sometimes they were called mentors or role models and sometimes they were just the right person with the right information at the right time. Most were located in the person’s city and organisation and seen daily, but there were

³⁷ Wright SM, Cohen DE, Kolobner K, Howard DM, Brancatti TF, Powell F. Attributes of excellent attending physician role models. *N Eng J Med* 1998;339:1986-1993

³⁸ Galicia AR, Klima RR, Date ES. Mentorship in physical medicine and rehabilitation residencies. *Am J Phys Med Rehabil* 1997;76:268-275

³⁹ Souba WW. The essence of mentoring in academic surgery. *J Surg Oncol* 2000;75:75 – 79

⁴⁰ Linney BJ. Characteristics of a good mentor. *Physician Exec* 1999;25:70-72

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some in another part of the country and seen on occasional visits but regularly talked to each other on the phone. Generally they were friends who created safe environments for learning, were protectors, gave specific feedback, viewed problems from a different angle, and stretched the thinking of those who sought their advice.

75. Based on the interviews of successful physician executives summarised in this article, most agreed that the term 'role model' was more comfortable to them than the word 'mentor' and that they only recognised these people as mentors when they looked back on their career paths – not at the time the interactions were happening.
76. Larkin⁴¹ suggests that
Mentorship may mean different things to different people, but the central role of guidance and protection remains.

⁴¹ Larkin GL. Mapping, modeling, and mentoring: charting a course for professionalism in graduate medical education. *Cambridge Quarterly of Healthcare Ethics* 2003;12:167-177

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3. How do authors describe the benefits of mentoring?

77. In this section an attempt is made to address this question from a number of different perspectives.
- In the one-to-one relationship
 - Beyond the one-to-one relationship
 - From the mentorship course
 - As a mentor
 - As a mentee
 - As a medical manager

UK literature

78. In assessing the literature, it is probably important to distinguish the benefits that enthusiasts claim from those that are reported as part of formal evaluations. Further it is perhaps useful to distinguish, if possible, between the benefits that participants report from having been on a mentorship course from the 'lived experience' of being a mentor or a mentee.
79. As a general concept the benefit of mentoring has been summarised by Pietroni⁴² as both enabling and cultivating in that it allows individuals to discover and use their talents creatively within a dynamic relationship that has, as one of its prime functions, the ability to make the most of human potential.
80. Based on a questionnaire evaluation, Connor and colleagues⁴³ who were the organisers of mentoring courses run by the Northern and Yorkshire Deaneries reported
- participants came to the programme with the intention of helping others, but they soon found that they were being helped themselves by becoming part of such a supportive network of senior doctors.
- The expected outcomes were to (1) develop mentoring skills and (2) set up mentoring networks for junior doctors whereas the achieved outcomes showed (1) being part of a network of senior doctors and (2) development of mentoring skills – as the most important achievements.
81. Doctor participants also reported that:
- the most useful elements in the course involved observing demonstrations of skills by facilitators and practising them with feedback in small groups.
82. Half of the doctor participants who answered the evaluation questionnaire gave specific ways in which the programme had helped them to achieve their potential in medicine. Enhanced confidence was mentioned most frequently as a factor. More than 80 per cent of doctor participants were positive about their ability to transfer skills learned on the course to their everyday life and work.

⁴² Pietroni R, Palmer A. Portfolio based learning and the role of mentors. *Education for General Practice*. 1995;6:111-114

⁴³ Connor, M.P. Bynoe, A.G. Redfern, N. Pokora, J. Clarke, J. Developing senior doctors as mentors: a form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors. *Med Educ* 2000;34:747-753

83. Sackin and colleagues⁴⁴ report the benefits of co-tutoring. Its most valuable aspect is the support that is perceived. Participants feel much more in control not only of their own learning but of many aspects of their professional and personal lives. The authors report that this process also lead to a reduction in stress. Participants in co-tutoring also report that the process of active listening improves their consulting skills and the authors suggest that the enhancement of listening skills is perhaps the major advantage of working with a co-tutor rather than a mentor.

it is clear that the support offered by this process builds a foundation that has helped some participants to bring about major changes in their lives and practices.

84. In a comparative study of mentoring (in which a GP educator-mentor visited practices) and co-tutoring, Hibble and Berrington report⁴⁵ the results of an evaluation conducted by postal questionnaire sent to all those who took part in the mentoring and co-tutoring schemes and to 119 GPs from practices where no partner was part of either process. A 72 per cent response rate was obtained. In the mentoring group the process was found to be highly acceptable and mentees described it as being informal, non-directive, insightful, supportive, relaxed, informative and non-threatening. Pre-mentoring stress levels fell in this group and participants described new coping strategies that many related to reducing or controlling workload. Co-tutoring was also found to be highly acceptable and most found the style to be exploratory rather than directive. Stress levels also fell. The non-intervention group reported an increase in stress in the same period. The authors conclude

Mentoring as a facilitating process can provide mentees with the opportunity and time to reflect on their development and how they might achieve goals. Co-tutoring offers a similar experience but with trained peers in a non-hierarchical situation.

and

The perceived a reduction in stress may be due to establishing the relationship or to the acquisition of new knowledge and skills.

and

it is possible that offering a colleague the opportunity to talk through personal and professional development and to make plans for the future within a supportive framework is sufficient to allow distressed doctor to feel in control.

85. Reporting the results of a questionnaire survey in May 1999 of 28 specialist registrar trainees in accident and emergency medicine, Okereke⁴⁶ reports that all 25 respondents had mentors and were familiar with the concept of mentoring with a mixture of selection of mentors and allocated mentors. All respondents met at least two to three times a year and over half met more than four times a year. The majority reported that mentoring helped preparation for appraisals and assessments. Ethnic minority and female trainees were most enthusiastic. The results of a survey

⁴⁴ Sackin P, Barnett M, Eastaugh A, Paxton P. Peer supported learning. *British Journal of General Practice* 1997;47:67-68

⁴⁵ Hibble A, Berrington R. Personal professional learning plans – an evaluation of mentoring and co-tutoring in general practice. *Education for General Practice* 1998;9:261-221

⁴⁶ Okereke CD. Mentoring – the trainee’s perspective. *J Accd Emerg Med* 2000;17:133-135

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of senior house officers⁴⁷ who were allocated mentors was overall less positive with 40 per cent saying that mentors were helpful. It is worth noting that 70 per cent only met once and that consultant time available was a barrier to meeting.

86. Gupta and Lingam⁴⁸ suggest that doctors in difficulty relating to training performance or immigration issues may find a mentor helpful. It further suggests that a mentor may be useful in career counselling.
87. Grainger⁴⁹ from the West Midlands Workforce Development Confederation reports that

Many people find a mentor useful at various stages in their lives. The three most common instances are:

- Mentees who are new to an organisation, and need to be equipped with knowledge about the organisation. They need help to apply what they've learned.
- Mentees who are concerned with career development (paths, opportunities, what's required for success) will need equipping with various competencies and help to explore possibilities and grow in new directions.
- Mentees who are being developed for future leadership or executive positions need help to prove their value and show their vision to an organisation. They may also need help to fill the gaps in their skill sets.

US literature

88. Barr and colleagues⁵⁰, authors of a 1993 paper in a radiology journal, consider that once the mentoring relationship is established there are numerous benefits. These include individual encouragement, honest criticism, advice on setting priorities and balancing responsibilities, knowledge of the informal rules for career advancement, proper behaviour in a variety of professional settings, the channels for establishing ties with the authorities in the various sub-specialties, and a perspective on long term career goals.
89. For the Editor-in Chief of *Postgraduate Medicine*⁵¹, the benefit to the mentor lies chiefly in the sharing of learning with junior colleagues.

As physicians, we accept the fact that we are lifelong students of the practice of medicine. We should also embrace teaching and sharing with others as part of the journey. The special skills and experience we develop in a particular area of medicine, patient education, or patient management become all the more valuable when shared with less experienced colleagues. Plus, it is exciting and fun to share expertise and watch colleagues grow. Unfortunately, the realisation that mentoring is both a source of personal satisfaction and a professional obligation often does not arrive until we have gray hair (just as interest in family reunions may not grow until we ourselves are the ones telling the stories.). When we return

⁴⁷ Okereke CD, Naim M. Mentoring senior house officers. Is there a role for middle grade doctors? *Emergency Medical Journal*, 2001;18:259-62

⁴⁸ Gupta RC, and Lingam SL. *Mentoring for doctors and dentists*. Oxford: Blackwell Science, 2000.

⁴⁹ Grainger C. Mentoring – supporting doctors at work and play. *BMJ* 2002;324:S203.

⁵⁰ Barr LL, Shaffer K, Valley K, Hillman BN. Mentoring. Applications for the practice of radiology. *Investigative Radiology* 1993;28:71-75

⁵¹ Setness PA. Mentoring. *PostgradMed* 1996;100:15-22

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from a CME course, we usually bring back a ‘pearl’ to help colleagues improve their medical skills. It may be even more valuable to offer personal pearls frequently in the form of emotional support or assisting in patient care. Such daily mentoring has the potential to improve our profession as well as satisfy our personal connection to our profession and our colleagues.

and

What could be more satisfying than to help a colleague become a better doctor or to learn more ourselves through a colleague’s experience? What could be more in tune with the goals of our profession than focussing on our skills rather than on dodging challenges because of the possibility of malpractice? What could be more fulfilling than helping a colleague in trouble rather than turning away?

90. In a review paper on the role of mentoring in psychiatry, Rodenhauser and colleagues⁵² suggest
many benefits accrue for students and residents fortunate enough to be involved in mentoring relationships including (1) guidance with socialisation into the profession, (2) assistance with stresses along the way, (3) help with the choice and fulfilment of a career path and (4) inspiration for meaningful involvement in activities such as research and administration. Implications of mentoring for faculty include recruitment, promotion, retention and satisfaction.
91. These authors (citing others) note that reported benefits to mentors include enhanced self esteem, stimulation of ideas and revitalisation of interest in one’s own work as well as professional assistance with projects, the close relationship with the protégé and the establishment of a long term friendship, direct financial rewards, indirect financial benefits (through success with grants or research or other professional pursuits). They refer to work by Silver (Silver MA. Administrative mentors for psychiatrists. *Psychiatr Serv* 1996; 47:536-537) who showed that mentoring was of particular value to psychiatrist-administrators.
92. One US paper gives details of a development programme based on peer mentoring⁵³. The outcomes of the programme in terms of overview of participants’ perspectives included a desire to continue or lengthen the programme, highlighting the learning environment as being particularly important because it was safe, supportive and fostered interpersonal communication, and because the dedication at regularly scheduled time for programme participation and reflection apart from the work environment. Participants repeatedly:
acknowledge that the safe, supported learning environment fostered by program facilitators contributed in important ways to their learning and relationship building and ultimately created a context that fostered their desire to attend the program regularly.
93. The authors conclude
a consequence of the safe environment that fostered participants’ interaction was the emergence of relationships, shared experiences, mutual problem solving, peer collaborations and camaraderie.
94. With the exception of one person

⁵² Rodenhauser P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

⁵³ Pololi LH, Knight SM, Dennis K, Frankel RM. Helping medical school faculty realise their dreams: an innovative collaborative mentoring program. *Acad Med* 2002;77:377–384

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those who had prior experience with other mentoring programs found peer mentoring at least as valuable as or more valuable than a senior faculty mentoring situation.

and

Critical to the meaningful learning outcomes participants associated with the program was the dedication of high quality, uninterrupted time away from clinical responsibilities to engage in discussion, acquisition and practice of skills, collaboration, and personal and career focussed self-reflection.

and

participants thus described the program context as dedicated, uninterrupted, quality time spent in a setting outside the work milieu that provided a safe, supportive, non-judgemental, open learning environment conducive to fostering interpersonal communication and relationship building.

95. The authors list the major programme outcomes as identified by participants as being (1) identification of individual governing values, (2) a structured process of short – and long-term career planning based on these core values, (3) the development of close, collaborative relationships, (4) skill development in such areas as gender, power, negotiation, and conflict management, scholarly writing, and oral presentation and (5) improved job satisfaction linked to the participants' decisions to remain in academic medicine and the resolve to remain at their current institution.
96. A study from neonatal pediatrics⁵⁴ showed that fellows who had a mentor were more prepared for academic practice and overall were more likely to be satisfied with their fellowship training.
97. Another study, undertaken in 1999/2000, based on telephone interviews of 16 faculty members⁵⁵, showed that for academic activities the highest ratings in a ranking exercise were given to mentors' assisting in preparation for promotion and helping mentees develop an independent academic identity. The lowest rating was given to mentors' ability to assist the mentees in negotiating their salaries. For psychosocial activities the highest ratings were mentors listening carefully to their mentees' ideas and concerns, setting a high standard for their performance and having a sense of the mentee as a person as well as a professional. Qualitative analysis of the interviews showed that participants reported the importance of responsiveness and availability in a mentor. They valued mentors who are knowledgeable and well respected in their field. An effective mentor values mentoring as an important part of his or her professional role and is dedicated to developing an important relationship with the mentee. Other benefits reported included having an 'academic parent' - the mentor works to support the personal and professional growth of the mentee or an 'academic coach' who provides guidance, motivation, strategic advice and skill development. The mentor also acts as an advocate, promoting the protégé [mentee] in the department and the academic community at large while sometimes protecting the mentee. The importance of

⁵⁴ Pearlman SA, Leef KH, Sciscione A. Mentorship in neonatal fellowship training – how well are we doing our job? Results from a national survey. *Pediatrics* 1998;102:771

⁵⁵ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. 'Having the right chemistry': a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

positive feedback and encouragement as well as constructive criticism is emphasised. Networking is an important and complex aspect of the mentoring experience that requires action by both parties. Mentors can teach mentees how to promote themselves as well as teaching them ‘the rules of the game’ of academic politics and networking. The authors report that the interviews showed that mentors can support mentees by having ‘a zero tolerance for discrimination.’ The complex role of the mentor is stressed.

98. Many disadvantages of not having a mentor were identified. Total lack of mentoring can result in stress, in less opportunity for academic advancement, and in financial disparities. Almost 98 per cent of participants identified lack of mentoring as the first or second most important factor hindering progress in academic medicine. The authors conclude that

having a mentor is critical to having a successful career in academic medicine.

99. The benefits of mentorship in a non-academic setting are also stressed by Wright and colleagues⁵⁶.

It further benefits the career development of young physicians providing a forum for a process to continue the life-long understanding of self that may conclude in enhanced professional fulfilment. Moreover, it may serve as the springboard for identifying other professional and personal interests that enhance job satisfaction and career focus.

100. Larkin⁵⁷ places mentoring alongside mapping and modeling as essential elements in developing the understanding and practice of professionalism.

In addition to using modeling and multimedia technology to teach professionalism, the creation of adviser-advisee dyads holds tremendous potential for fostering professionalism and, when necessary, remediation.

and

Mentoring engages students and residents in the conversation of what their life will be about and focuses on their interests, skills, and life goals as professionals. This approach has also been shown to enhance the mission of lifelong learning by increasing the human capital and productivity of the participants. Drew Appleby reflects on the value of the educational enterprise when mentors are involved by quoting Henry Cardinal Newman:

‘[University training] shows us how to accommodate ourselves to others, how to throw ourselves in their state of mind, how to bring before them our own, how to influence them, how to come to an understanding with them, and how to bear with them.’

This consideration for others, I submit, is integral to professionalism and is the prize of a well-mentored medical education. Although being a mentor is not for everyone, many aspire to find a humble, wise Yoda (Luke Skywalker's mentor) who may honor our own dreams and visions, bring out our best, and help us realize that, in spite of current odds, one person can still make a difference.

⁵⁶ Wright WR Jr, Dirsra AE, Martin SS. Physician mentoring: a process to maximise the success of new physicians and enhance synchronization of the group. *J Med Pract Manage* 2002;18:133-137

⁵⁷ Larkin GL. Mapping, modeling, and mentoring: charting a course for professionalism in graduate medical education. *Cambridge Quarterly of Healthcare Ethics* 2003;12:167-177

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4. How do authors describe the benefits to organisations?

101. In this section an attempt has been made to summarise how authors describe the benefit to organisations, with particular reference to:
- a) How organisations are involved - Degrees of ownership and control
 - b) Benefits: perceived and measurable
 - c) Investment and return.

UK literature

102. Several UK authors emphasise that the benefit that accrues from mentoring goes beyond an intervention at the start of a career. Freeman⁵⁸ cites the contribution mentors can make in helping a workforce facing imposed organisation change such as currently experienced in the NHS which

when not properly managed, results in individual stress, role confusion and disillusionment with the task. This quality of mentoring is not easily achieved in an imposed, institutionalised mentoring programme but it can and should be worked towards.

and

whilst modern mentoring is adapted to the needs of the organisational context in which it appears, it is in danger of losing its identity if it forfeits too many of the core characteristics which distinguish mentoring from other forms of intervention. 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.

103. Alliot⁵⁹ comments

it is difficult to expect GPs to look after patients properly if they have major educational needs or disturbing personal problems. We see mentoring as a means of establishing a culture where sensitive issues and vulnerabilities can be openly raised to reflective constructive discussion.

104. Young, also a GP, states⁶⁰

meeting regularly away from work with a trained colleague provides focused and sympathetic attention of a skilled person with confidentiality. This allows reflection on any aspect of work, difficulties experienced and opportunities arising, educational issues and professional development.

and

mentoring and co-tutoring may also help doctors to feel valued and doctors who feel valued and have time to reflect and develop probably provide better quality services to patients. Mentoring, therefore, has a contribution to make to the development of clinical governance.

⁵⁸ Freeman R. Faculty mentoring programmes. *Med Educ* 2000;34:507-508

⁵⁹ Alliot R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

⁶⁰ Young G. Mentoring should be more widespread. *BMJ* 1999;319:852-853

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US literature

105. Many of the US papers refer more to the sustenance and development of particular academic programs and academic disciplines rather than specific local organisational benefit. The background to a study by Pololi and colleagues⁶¹ from Worcester, Massachusetts and North Carolina was the increasingly heavy focus on clinical practice and economic pressures in health care, both of which have resulted in less time being allocated per clinical encounter and less time for teaching and mentoring of medical students and residents, which has become a hindrance to clinical income expectations. In the authors' view this means that
- it is more essential to encourage and support vitality and learning of the physician faculty.
106. These negative influences may also account for high faculty turnover rates. This needs analysis study shows that the institutional perspective (as reported by senior administrators) on faculty development priorities was focused on commitment to the organisation, job skill development and time management. In contrast, the faculty prioritised renewal, sustaining their vitality, balancing personal and professional lives, finding meaning in their work, relationships and personal growth. The authors suggest this disparity may contribute to the attrition occurring in academic medicine and suggest the need for improved communication at all levels. They conclude
- we interpret the findings of our investigation as a call by our faculty to become part of a community in learning in which, individually, they can find support and encouragement for the personal and professional growth and in which they can express confusion and vulnerability without fear of humiliation or reprisal.
107. Looking more specifically at the benefit to one type of organisation in which doctors work – the medical group practice - Wright and colleagues⁶² distinguish mentoring from orienting/training although they are complementary. From the organisation's perspective mentoring
- is intended to reduce the shock of entry for the newcomer and facilitate preparation for effective integration into the group, enhancing productivity and working successfully within the parameters of the group. Moreover, mentor relationships provide a social forum for the organisation. Members learn the ropes of the organisation and are less likely to leave because of confusion and frustration.
108. They conclude
- of the multitude of factors that serve as the ingredients for a healthy and successful medical group, none is more important than the people. In a medical group practice, physicians ensure that the culture is grounded on a set of values and principles that promote team work and focus. Without it, the environment is destined to be based on hypocrisy and distrust. Organisations that take the time and commit the energy to effectively mentor new physicians will have the best chance of maintaining synchronisation based on the alignment of individual expectation and the realities of the organisation.

⁶¹ Pololi LH, Dennis K, Winn GM, Mitchell J. A needs assessment of medical school faculty: caring for the caretakers. *Journal of Continuing Education in the Health Professions* 2003;23:21-29

⁶² Wright WR Jr, Dirsra AE, Martin SS. Physician mentoring: a process to maximise the success of new physicians and enhance synchronization of the group. *J Med Pract Manage* 2002;18:133-137

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109. Returning to the needs of academic disciplines, Barr and colleagues⁶³ in a 1993 paper from radiology state
- what research is available and overwhelming anecdotal evidence indicates the importance of mentoring to radiology. Mentor-protégé relationships are beneficial to the mentor, the protégé and the profession.
110. A paper in 2000 from the Department of Radiology at Stanford University sets out an evaluation of a mentoring program instituted in 1995 (which also included faculty day-long retreats and bimonthly open-forum meetings and mentoring-related seminars). The authors, Illes and colleagues⁶⁴, conclude
- The data we present herein provide evidence of the desirability and acceptance of a mentoring program in the academic radiology setting. Most important, both junior faculty and mentors considered the program to be extremely important. We attribute performance improvements both to the experience that is gained naturally over time combined with the formal mentoring that the program provided. Given the consistency of the ratings during the five test periods years since 1989, the program has been instrumental in providing clarity and definition of career pathways in academic radiology for the new faculty, enhancing overall communication and information flow among all faculty and staff within the department, and supporting the research and extramural funding success of all faculty. In the past 2 years alone (1998 and 1999), 11 assistant professors have been promoted, including three women, two of whom are also members of an ethnic minority group, and another two minority faculty. Women now represent 11% of the faculty and, together with other women faculty who are still at the junior level, already lead major departmental programs in thoracic imaging, breast imaging, musculoskeletal imaging, interventional magnetic resonance, and outcomes analysis. These women will now serve as professional advisors and advocates for more junior faculty women and as role models for the development of their professional identity.
111. A survey of gastroenterology research fellows, published in a 1999 paper by Hosseini and colleagues⁶⁵, showed
- There were significant differences between fellows who would train again at the same institution and those who would not. Inadequate clinical instruction, supervision, research mentorship, autonomy in making clinical decisions, and support services, and financial insecurity were reported among fellows who would not train again at their institution. Although the great majority of fellows were happy about their career choice, adequate research mentorship was believed to be lacking in many programs.
112. The authors suggest
- a mentor assigned early in fellowship to each trainee and a core research curriculum may remedy this problem.
113. Having a mentor has been shown to be important in choice of academic career as shown in a 2001 paper⁶⁶ that reports the results of a questionnaire survey sent to 86

⁶³ Barr LL, Shaffer K, Valley K, Hillman BN. Mentoring. Applications for the practice of radiology. *Investigative Radiology* 1993;28:71-75

⁶⁴ Illes J, Gover GH, Wexler L, Leong ANC, Glazer GM. A model for faculty mentoring in academic radiology. *Acad Radiol* 2000;7:717-724

⁶⁵ Hosseini M, Lee JG, Romano P, Hosseini JD, Leung J. Educational experiences and quality of life of gastroenterology fellows in the United States. *American Journal of Gastroenterology* 1999;94:3601-3612

⁶⁶ Thakur, A, Sedorka P, Cohen, C, Buchmiller-Kreyer, T.L, Atkinson, J.D. and Fonkelsrud, E.W. Impact of mentor guidance in surgical career selection. *J.Ped.Surg.* 2001;26;12:1802-1804

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graduates of the UCLA general surgery program who matriculated from 1975 to 1989. The aim was to survey graduates to determine factors that influenced their selection of specialty field. In a 65 per cent response rate, 80 per cent of respondents identified retrospectively the following factors as being most important in their choice of specialty: interest in that field, perception of prestige, presence of clinical opportunity, mentor influence and family priorities. The authors comment that the influences that guide selection of specialty field are multi-factorial: interest in the field being the strongest influence, sometimes in advance of competence. Income was not a factor in influencing the decision. The authors state

mentors were very important to respondents in this survey in their pursuit of a specialty.

114. The same paper from neonatal pediatrics⁶⁷ mentioned earlier also points to benefit that mentoring brings to the discipline in that the three most important reasons for choosing a neonatal fellowship were location, reputation and faculty. The presence of a mentor correlated with being prepared for academic practice, plans to enter academic practice and recommending the fellowship to others.
115. A survey of physicians recently completing geriatric fellowships⁶⁸ (62 per cent of 787 physicians responded) showed that a mentor influenced the decision to pursue a career in geriatrics during residency training in 48 per cent. In a follow-up letter⁶⁹, the authors conclude that
the role of mentorship in geriatrics should hence not be understated. The field must assure that exemplary faculty are present in geriatric medicine to serve as role models for all levels of trainees, including medical students, resident physicians in multiple specialties, and geriatric fellows. The future of academic geriatrics relies on encouraging and sustaining career interest as clinician-educators and research scientists.
116. A letter from public health physicians⁷⁰ suggest that mentoring may be one way of addressing some of public health's most pressing issues which include a dearth of leadership, personal shortages in every health specialisation, the need for unification of public health professionals and better understanding and support of public health initiatives among the general public. The authors suggest that mentors can
offer essential guidance, encouragement and insight in times of uncertainty and stress.
117. In the detailed review of mentoring in psychiatry mentioned earlier⁷¹, the authors also consider that mentoring is important for the health of the discipline.

⁶⁷ Pearlman SA, Leef KH, Sciscione A. Mentorship in neonatal fellowship training – how well are we doing our job? Results from a national survey. *Pediatrics* 1998;102:771

⁶⁸ Medina-Walpole A, Barker WH, Katz PR, Karuza J, Williams TF, Hall WJ. The current state of geriatric medicine: a national survey of fellowship training geriatricians. 1990 – 1998. *J Am Ger Soc* 2000;50:949-955

⁶⁹ Medina-Walpole A, Barker WH, Katz PR, Karuza J, Williams TF, Hall WJ. A tribute to mentors in geriatric medicine: results of a national survey of fellowship-trained geriatricians 1990 – 1998. *J Am Geriatr Soc* 2003;51:726

⁷⁰ Mahayosnand, P.P. & Stigler, M.H. The need for mentoring in public health. *Am J Public Health* 1999;89:1262-3

⁷¹ Rodenhauer P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

As part of the specialty of psychiatry mentoring is not only part of the teacher-student and supervisor-supervisee relationship but also part of the psychotherapeutic relationship. Mentoring has implications for recruitment of medical students into the specialty, acculturation of residents into the theory and practice of psychiatry, support for career development in subspecialty areas, attraction to and encouragement of research as well as other academic pursuits, junior faculty career development and patient care.

118. Although papers from different specialties advocate mentorship, some also point to the dearth of mentors. Galicia and colleagues⁷², describing mentorship in physical medicine and rehabilitation (PM&R) residencies, state

mentorship is considered by many authorities as being possibly the most important tool for the progression of a professional in training.

and

despite the vast majority of residents (97.3%) who responded that mentorship during PM&R training was a good concept, only about one in three of the respondents had a mentor before their PM&R residency and one in four during their residency. Those who had a mentor before PM&R residency indicated a positive effect on their decision to choose PM&R as a specialty. 75.8% of the mentoring relationships in which a mentor was more than 15 years older were formed by free choice.

119. Two large surveys of obstetric and gynecology fellows and residents (over 6,000 people in all) showed concerns about how mentoring was being practised. The authors⁷³ conclude

in sum, our findings do not paint an encouraging picture of the ability of obstetrics and gynecology to use mentoring to attract and retain women and minorities to academic faculty positions and positions of leadership. There is also an indication that men as well may be experiencing discrimination in the mentorship they receive..... A bridge to race, ethnicity and gender diversity requires current leaders to be role models of positive and unbiased mentorship.

120. The findings of inadequate availability of mentorship are echoed in a short paper from Seattle⁷⁴, looking at obstetrics and gynecology and surgery. It reports the prevalence and characteristics of mentorship among junior faculty in clinician-scientist and clinician-educator tracks. All 162 junior faculty were surveyed in the clinician-scientist and clinician-educator tracks of the Departments of Medicine, Obstetrics and Gynecology and Surgery. Respondents ranked the extent to which they agreed with a number of statements on a five point scale. The response rate was 75 per cent with a mean age of 38.7 years, 56 per cent were women and 36 per cent were mentored. Mentored faculty were more likely to be men, clinician-scientists, fellowship-trained and have access to senior faculty. After adjustments for age, years on faculty and fellowship training, mentored faculty were still more likely to be men and clinician-scientists. The authors conclude

⁷² Galicia, A.R, Klima, R.R. and Date, E.S. Mentorship in physical medicine and rehabilitation residencies. *Am.J.Phys.Med.Rehabil.* 1997;76:268-75

⁷³ Cain, J.M. Schulkin, J. Parisi, V. Power, M.L. Holzman, G.P. and Williams S. Effects of perceptions and mentorship on pursuing a career in academic medicine in obstetrics and gynecology. *Acad Med.* 2001;76:628-634

⁷⁴ Chew, L.D. Watanabe, J.M. Buchwald, D. and Lessler, D.S. Junior faculty's perspectives on mentoring. *Acad.Med.* 2003;78:692.

less than half of the junior faculty felt adequately mentored, suggesting that all junior faculty may benefit from improved mentoring. In particular, women and clinician-educator faculty are at risk for inadequate mentorship. Although access to a trusted senior faculty member was significantly associated with adequate mentorship, it may not meet the needs of many junior faculty, particularly clinician-educators. Therefore, mentoring programs relying solely on linking junior and senior faculty may be insufficient.

5. How do authors report forms of mentoring available to doctors?

121. In this section an attempt has been made to show how the literature describes the different forms of mentoring available to doctors in the UK and in the USA.
122. During 2002 the author of this review collated information about more than 50 schemes for doctors in the UK but few of these seem yet to have been described in the published literature. Unlike the US literature there seems to be little written about the value of mentoring for younger members of academic departments in the UK.

UK literature

123. Pietroni and Palmer⁷⁵ distinguish three types of mentoring (citing Morton-Cooper A, Palmer A. Mentoring and preceptorship. Oxford: Blackwell Scientific Publications, 1993). They are 1) classical or informal mentoring, 2) contract or formal mentoring and 3) pseudo-mentoring.
124. Classical or informal mentoring involves two self-selecting individuals with initially the learner being dependent on the mentor but the relationship becoming reciprocal and more emotionally intense with time. The role of the mentor is determined by the individuals in the relationship and there is no financial incentive. The relationship can last between two and 15 years.
125. Contract or formal mentoring lasts for a shorter time and is artificial, created for a specific purpose which is determined by the organisation. There may be some degree of negotiation but the role of the mentor is defined by the programme's aims. The mentor is assigned to the individual (forced matching) or the individual may make a choice from a selected group of mentors (mentor pool). The mentor may receive material or financial reward and the duration of the relationship is determined by the organisation and is usually less than two years.
126. Pseudo-mentoring confuses mentoring with the provision of support for a specific task and is often offered by organisation or academic institutions as a facet of educational supervision, for the purpose of thesis preparation or part of an orientation programme. It is of short duration, usually less than one year.
127. Savage and Playdon⁷⁶ in a review of the role of an 'educational supervisor' that encompasses many different functions - teacher, programme coordinator, assessor of competence, mentor, career adviser, appraiser and counsellor - suggest that the role has become too wide ranging to be filled by a single consultant, already busy with clinical responsibilities. Citing Parsloe, (Parsloe E. Coaching, Mentoring and Assessing. London: Kogan Page, 1992) they suggest that most trainees benefit from having a mentor to whom they can turn for advice and guidance.

Every hospital should have a panel of consultants representing all clinical specialities, who are recognised for their empathy and expertise in the problems

⁷⁵ Pietroni R, Palmer A. Portfolio based learning and the role of mentors. *Education for General Practice* 1995;6:111-114

⁷⁶ Savage PEA, Playdon ZJ. Whither the educational supervisor. *Br J Hosp Med* 1995;54:55

that trainees have to face. This panel should be recruited by the clinical tutor, and the names made available to trainees when they start their appointment. At an early interview with the clinical tutor, the trainee is invited to make contact with a mentor of his/her own choice.

128. Gupta and Lingam's booklet⁷⁷ puts forward a three stage model of mentoring (1) exploration, (2) new understanding, (3) action planning.
129. Connor and colleagues⁷⁸ provide an account of the Northern and Yorkshire Region Doctors' Development and Mentoring Network which was set up in 1994. The objectives of the network were to 1) develop mentoring skills 2) provide a forum for personal and professional development for senior doctors and 3) develop a mentoring network for junior and senior doctors. The programme had initially focussed on women doctors but, in order to develop a robust mentoring network for junior doctors, both men and women were needed to be involved.
130. The main elements of the programme are listed as being (1) defining mentoring, (2) understanding the mentoring process, (3) learning and using a model of the process and skills (Egan), (4) managing the mentoring relationship, (5) ethical and professional issues in mentoring, (6) personal and professional development, (7) developing networking in Trusts and localities and (8) setting up mentoring for juniors.
131. For these authors, the role of mentoring is
to provide experience, objectivity and empathy together with the ability to influence events.
132. Citing evidence from the Ashridge Management Research Group, they suggest that formalised mentoring arrangements can be as good as naturally occurring mentoring. During the programme, participants worked in groups of three, rotating the roles of mentor, mentee and observer, and learning how to give honest and constructive feedback to one another and how to self-disclose appropriately in order to help the mentor deal with the real material.
133. The paper recounts the lasting impact for participants in this programme in terms of their life and work, including their ability to set up local mentoring networks. Two important findings were
Although the original intention of mentoring training was to develop skills to use with junior doctors, it became apparent that the senior doctors were gaining much from using these skills in co-mentoring, both formally and informally.
and
Another welcome surprise has been the extent to which the framework for the mentoring process and the associated skills have been transferable to ordinary work situations, with patients, relatives and colleagues.
134. The general practice models developed in east Anglia are explained in different papers by Alliott, Sackin and colleagues and Eastaugh and colleagues. Alliott's paper⁷⁹ reviews the development of a method for facilitatory mentoring, defined as

⁷⁷ Gupta RC, Lingam SL. Mentoring for doctors and dentists. Oxford: Blackwell Science, 2000.

⁷⁸ Connor, M.P. Bynoe, A.G. Redfern, N. Pokora, J. Clarke, J. Developing senior doctors as mentors: a form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors. *Med Educ* 2000;34:747-753

⁷⁹ Alliott R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

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dialogue between two autonomous practitioners on a voluntary basis.

and

mentors meet with 'mentees' to talk through any impediments or problems which are obstructing personal and professional development. For their part, mentees are encouraged to speak up about any obstacles and explore potential remedial action with the mentor, facilitating constructive reflection. The mentee sets the agenda on which both pastoral and educational issues may be discussed.

135. The paper explains the underlying approach in mentor/mentee meetings including starting by asking 'how are things going?' Opening topics frequently involve issues such as living with uncertainty, unresolved complaints, feelings of inadequacy or loss of control of working lives.
136. The issues most commonly raised are listed. Alliott states
Anglia mentors have found the use of anecdotes and the sharing of mistakes and common vulnerabilities helpful in gaining trust, reassuring the mentees and encouraging further disclosures.

and

Dealing with mentees' personal issues can be stressful.

and

Mentoring in general practice facilitates personal/professional development looking at both educational and pastoral issues as the mentee's agenda dictates.

137. In the paper by Eastaugh and colleagues⁸⁰, the authors explain that co-tutoring (which is also known as co-mentoring) takes a different approach in that it is a system of peer supported learning based on a relationship of parity, whereby participants facilitated each others thinking and reflection to enable them to address the problems that are pertinent to their individual situation. This active listening with facilitated intervention can help overcome unrecognised emotional blocks which inhibit rational thought.
138. The co-tutoring process is modelled in preparatory workshops that consist largely of exercises in pairs or trios with each participant taking turn as a listener, speaker and observer. Areas covered include listening skills, feedback, dealing with feelings, self disclosure and action planning. Participants are then invited to form co-tutoring groups.
139. A format for co-tutor meetings is listed in the paper. It allows each participant time as speaker and listener. The content of these sessions is decided by the co-tutors. Follow-up workshops are provided for support and encouragement and to enhance and develop skills. The wider support and stimulation offered by these sessions is seen has had at least as important as the co-tutoring itself.
140. Sackin and colleagues⁸¹ explain that to address voiced concerns about collusion and even destructiveness in a co-tutoring relationship, it is important to offer more than just the facility for co-tutors to meet. The east Anglia scheme involves a two-day introductory residential course and regular follow-up days for the group.

⁸⁰ Eastaugh A, Barnett M, Parlby S, Paxton P, Sackin P. Co-tutoring: peer-supported learning. *Education for General Practice* 1998;9:517-519

⁸¹ Sackin P, Barnett M, Eastaugh A, Paxton P. Peer supported learning. *British Journal of General Practice* 1997;47:67-68

These allow participants to develop their skills in co-tutoring and to gain support and new ideas. The facilitators are also available to individual pairs for supervision.

141. Bregazzi and colleagues⁸² describe an arrangement in County Durham to provide a mentor for salaried, post-vocational training scheme GPs and GP returners working under the Career Start scheme. The seven GPs who participated in the study selected their mentor practice from a list of 12. No specific training was provided for the mentors who were GPs working in the same practice as the participating GPs. Some mentors had experience as GP educators.

142. Based on interviews of the seven GPs and their GP mentors, the authors comment

Experience in County Durham suggests that successful mentoring in this context depends on having a clear and limited purpose, time, adequate training, and the formation of a relationship that is uncomplicated by power dynamics or role conflict. Dysfunctional mentoring relationships place stress on learners, particularly if they are accountable to their mentor. Learners need options to choose their mentors, a negotiable process and a mechanism to review the relationship.

and

Two strands of support for the new GP emerge from the experience of Career Start, mentoring and induction into the particular practice. While induction and the need to maintain an environment within which new GPs can flourish remains a practice responsibility, GP tutors are well placed to act as mentors for newly qualified GPs.

143. The 2002 paper by Roberts and colleagues⁸³ describes a mentoring scheme started in the south west of England for newly appointed consultant psychiatrists. The origins of the scheme lie in concerns about low recruitment and retention of consultant psychiatrists, the need to find ways of preventing work related ill health, stress and burn out, and to sustain their creative and productive engagement in health care. The paper looks at problems currently facing practitioners: understaffing, poor premises, low morale, unacceptable work loads, feeling of being dispossessed of their professional role and autonomy, violence and the fear of violence, a culture of blame, failure of management and a lack of support from colleagues. The authors suggest that doctors work in a culture of blame and error and psychiatrists, in particular, increasingly work in isolation. Although part of multidisciplinary teams they suffer from relative isolation from their peers, apart from formal meetings to address specific agenda. The lack of a confidant has been associated with an enhanced risk of anxiety and depression in health care staff. The early years in post are considered to be the most difficult. The authors suggest that mentoring has the joint aspiration of promoting occupational health and supporting the development of professional confidence.
144. During 1999, consultants in psychiatry five years in post were contacted and asked to help develop an appropriate support system. They were offered to attend a training and development course which was designated as 'a day of mentorship on

⁸² Bregazzi R, Harrison, J and van Zwanenberg T. Mentoring new GPs: experiences from GP Career Start in County Durham. *Education for General Practice* 2000;11:58-64

⁸³ Roberts G, Moore B, Coles C. Mentoring for newly appointed consultant psychiatrists. *Psychiatric Bulletin* 2002;26:106-109

mentorship'. The workshop clarified the central aims and purposes of mentoring which the authors consider was helpful to define the extent of the commitment, possible pitfalls and common mistakes. Mentors, in particular, do not aim or offer to be therapists. According to the authors, the induction process for mentors was designed to mirror the mentor relationship.

145. In this scheme, newly appointed consultants are contacted by the scheme coordinator, encouraging them to access mentors who have produced a brief pen portrait of themselves. Mentees are asked to contact their chosen mentor and to inform the scheme coordinator. Mentors are offered within a reasonable travelling distance, outside their own trust and are asked to support only one colleague. There is an initial meeting to discuss the prospect of mentoring without commitment. This may be followed by a period of six months with the option of opting out and followed by a notional two year 'contract'. The authors suggest that annual induction and review days for mentors will be a means of democratically shaping the development of mentoring. However, the authors consider that it is important to have a high degree of flexibility and scope for negotiation.

It is a relationship shaped by guidelines rather than rules.

146. Newly appointed consultants in one trust in Kent are the focus of a mentoring scheme organised as part of a wider induction programme, reported by Black⁸⁴ in 2002.

All newly appointed consultants are offered the opportunity to have a mentor from among the senior consultants within the organisation. Mentors are chosen on the grounds that they do not have major management roles within the organisation, are prepared to do it and are individuals perceived to be approachable, and with common sense. When the scheme was started, training was not arranged but, subsequently, around half of the newly appointed consultants took up the opportunity for training.

Arrangements, including the subjects to be discussed, whether meetings would happen at all or how frequently, the site of the meeting and how long the relationship might last, were left up to the mentor and mentee to discuss together.

147. The author, who is medical director of the trust, states

The programme was reviewed in both 1999 and in late 2000 and the findings were very similar. A small number of people did not meet at all. The rest met for a minimum of one and a maximum of four occasions. The main issues discussed were: relationships with colleagues, who to take problems to, and hospital politics and resource problems. Issues discussed less frequently included time management, juniors' problems and frustrations with clinics. Two-thirds of the mentees thought that the programme was helpful and about half the mentors thought that the programme was helpful. Interestingly, there was always one party in every pair who thought the process was helpful. Both reviews believed that the process should continue.

On reflection, it would appear that the programme as currently operated is more about opportunities for confidential induction discussions, rather than a full-blown mentoring programme as described by SCOPME. Ideally, there should have been training for all mentors before the programme started and there is little doubt that there should be more opportunities for mentors and mentees to choose their own partners. Mentoring may also work better if it is with someone

⁸⁴ Black D. Induction for newly appointed consultants. *Clinician in management* 2002;11:9-13

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in the same specialty. However, this programme was deliberately set up not to be in the same specialty, as it was thought likely that many of the problems would be colleague related in their new departments and the most important opportunity would be to discuss this confidentially with someone outside the department.

However, the feedback, both of the specific programme and of the survey (see later), suggested that enough people gain from this to continue to offer the programme to all consultants when they start.

148. A personal view by Waters⁸⁵ gives an account of the uncomfortable experiences of the author on his first day as a new consultant in 1985. Following this, an induction programme was started but he felt that more was needed. He modelled a mentorship programme on that which had been instigated at a nearby trust. The author used the same company offering a day and a half long course in mentoring skills for consultants. Two facilitators ran the course, both of whom were experienced at board level in the NHS and private sector. The 'master class in mentoring' analysed the role of the mentor and the structure of a mentoring session and discussed and practised mentoring skills, including how to listen, give feedback and build a relationship. The course also employed the Myers-Briggs type indicator to help develop mentoring skills.
149. Before the master class, each participant had already agreed who they would mentor. On the follow-up course, all had completed one or two mentoring sessions with their chosen mentee. The author concludes

through the mentoring scheme, we hope to build a network of supportive, professional relationships that will help us work together better for the benefit of our patients. It will also ensure that no new consultant feels so alone as I did on that first day.
150. Okereke⁸⁶ gives an account of a mentoring scheme introduced to the accident and emergency (A&E) trainees in the Yorkshire region in 1997. A regional coordinator sends out the names of 15 volunteer mentors to prospective mentees who then choose a mentor. They remain together for the duration of the mentee's training. Mentors are encouraged to attend the regular, semi-formal training meetings.
151. In another paper from A&E, Okereke and Naim⁸⁷ give an account of an evaluation of a mentoring scheme for senior house officers (SHOs). The paper suggests that a major limiting factor was time available to meet with consultant mentors. On the other hand responders felt that their relationship with middle grade doctors was very good and that they were more readily available, would have more time and show more commitment. Those responders who rejected middle grade mentors felt that they would be uncomfortable discussing private issues with them. The author suggests that middle grade doctors, especially in A&E departments are in a unique position to offer practice advice, emotional support and feedback. Offering middle grade doctors the time and resources to serve as mentors will also provide philosophical support and a sense of fulfilment.

⁸⁵ Waters, E. Consultants. 'I felt very alone.' *Health Serv J* 2002;112:26

⁸⁶ Okereke CD. Mentoring – the trainee's perspective. *J Accd Emerg Med* 2000;17:133-135

⁸⁷ Okereke CD, Naim M. Mentoring senior house officers. Is there a role for middle grade doctors? *Emergency Medical Journal*, 2001;18:259-62

US literature

152. The predominant model in the US literature is that of ‘faculty mentoring’, many of the elements of which have already been described. Although the purpose and benefits are described alongside the roles of mentors and protégés (see the next two sections), rather little is written about how the interactions are or should be conducted. This is in contrast with the UK literature which describes this in some detail.
153. Authors emphasise that time spent by mentors and protégés together is a crucial ingredient to success, as well as availability of suitable mentors. Gender and race issues are prominent but are complex⁸⁸. The conclusions across a number of papers appears to be that, whereas having a mentor of the same gender and/or race is not itself important, the availability of mentors of both genders and from all ethnic groups is important. Some disciplines have recorded shortages of suitable mentors, particularly women. In response to this, Schapira and colleagues⁸⁹ from general internal medicine suggest ways forward, including providing pairing with an ‘academic friend’ who might be a peer or a junior and who would provide social support, and tapping into intellectual networks which may provide potential mentors outside the home institution.
154. The authors conclude that it may be important for a trainee to use several mentors with each of them performing some of the important mentoring functions, e.g. one mentor may be important for editing papers, another for developing research ideas and a third for emotional and social support in the division.
- This flexibility will enable the trainee to establish a supportive and educational environment even if the ‘ideal’ well rounded mentor is not available.
155. There is also discussion in the literature about formal versus informal mentoring arrangements. In a survey (40 per cent response rate) of over 1000 residents in physical medicine and rehabilitation (PM&R), Galicia and colleagues⁹⁰ state that the results of the study agree with prior findings of other researchers that the success of formally assigned mentoring programs is limited (quoting Noe, R.A. An investigation of the determinants of successful assigned mentoring relationships. *Personnel Psychology*, 1988; 41: 457-479 and Conrad, C. *Strategic organisational communication: cultures, situations and adaptation*. New York: Holt, Rinehart and Winston, 1985.)
- Resident satisfaction was higher in mentorships formed by free choice compared to those that were assigned. Residents and mentors in mentorships formed by free choice more likely maintained a social relationship and communicated more frequently compared with those in assigned mentorships.

⁸⁸ See: Cain JM, Schulkin J, Parisi V, Power ML, Holzman GP, Williams S. Effects of perceptions and mentorship on pursuing a career in academic medicine in obstetrics and gynecology. *Acad Med* 2001;76:628-634

and see Rodenhauser P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

⁸⁹ Schapira MM, Kalet A, Schwartz MD, Gerrity MS. Mentorship in general internal medicine: investment in our future. *J Gen Intern Med* 1992;7:248-51

⁹⁰ Galicia AR, Klima RR, Date ES. Mentorship in physical medicine and rehabilitation residencies. *Am J Phys Med Rehabil* 1997;76:268-275

156. The authors state, however, that the importance of frequent communication is paramount to the success of mentorships. Correlation was significant at $p < 0.0001$, irrespective of whether the mentorship was formed by free choice or assigned. The authors conclude that
- given that initiation of mentorships formed by free choice may require time, assigned mentorship, although not preferred, could be a practical alternative in the early stages of residency training.
- In light of our findings, primary focus in pairing attending and protégé in assigned PM&R mentorships should be on encouraging frequent communication, rather than matching race or gender. Frequent communication may be facilitated by scheduling early residency training rotations based on these mentorship pairings. Assigned PM&R mentorships may also be improved by establishing a protocol that would allow, and even encourage, the resident to add an additional mentor or replace the assigned mentor if the mentorship is not satisfactory as the resident progresses through training.
157. Some authors are not convinced of the value of formalised arrangements, often where mentors are assigned to protégés. Tucker and Adams-Price⁹¹ cite Kiley (Kiley, M.C. A piece of good news: teaching as a creative process. *Canadian Psychology*. 1999; 40: 30-38) who has argued that formalising the relationship between mentor and protégé can reduce the likelihood that the protégé will complete the program. Kiley reported that students who left their programs without completing their dissertations had more formal relationships with their mentors than similar students who had completed their programs. In addition, Kiley has argued that formalising the mentor-protégé relationship may reduce the creative potential of the collaboration, suggesting that when mentors and protégés have friendly relationships, protégés may feel more inclined to brainstorm about research ideas and less inclined to conduct a less original, ready-made project supplied by the mentor. These authors cite Bowman (Bowman VE, Hartley LD and Bowman RL. Faculty-student relationships: The dual relationship controversy. *Counsellor Education and Supervision* 1995; 34: 232-242) and Kelly and Schweitzer (Kelly S, Schweitzer JH. Mentoring within a graduate student setting. *College Student Journal*. 1999; 33: 130-148) as reporting similar findings.
158. Informality of a different kind is mentioned by Wright and colleagues⁹². They suggest that a forum for establishing and maintaining a relationship includes
- (1) Early communications to establish a friendly peer relationship. This easily accomplished with e-mail and/or the telephone. It should be fun and informal.
 - (2) Bi-weekly meetings (perhaps over lunch).
 - (3) Routine calls from the mentor to the protégé just to check in and see how things are going.
 - (4) Open access from the protégé to the mentor to seek advice or questions.
 - (5) Occasional invitations to have dinner at the mentor's home. Meeting the other's family and knowing them on a personal basis builds a trusting bond.
159. From the point of view of academic pediatrics, Bauchner⁹³ divides mentoring into two categories: research and career which differ in terms of (1) goals, (2) skills and

⁹¹ Tucker RC, Adams-Price CE. Ethics in the mentoring of gerontologists: right and responsibilities. *Educ Gerontol* 2001;27:185-197

⁹² Wright WR Jr, Dirsra AE, Martin SS. Physician mentoring: a process to maximise the success of new physicians and enhance synchronization of the group. *J Med Pract Manage* 2002;18:133-137

(3) the fundamental relationship between the mentor and the mentee. The research mentor helps to develop the research career of the mentee which involves acquisition of research skills, selecting and conducting a research project, presenting findings, submitting manuscripts, assisting in networking and teaching the mentee how to obtain extramural funding. Bauchner contrasts this with the career mentor who

focuses on more global aspects of an academic career, including balancing family demands and work, career promotion, juggling the different aspects of academic life (teaching, administration, clinical care, and research) and major career decisions, such as changing institutions or research direction.

160. The author also divides the research mentor-mentee relationship into informal and formal and also distinguishes project-specific mentoring.
161. Jackson and colleagues⁹⁴ give guidance to individuals and to institutions. For the individual they suggest that faculty members must be diligent in seeking out a mentor and be explicitly aware of the personal and professional qualities they value, and discuss these to find the right match. They should be alert to the fact that a few mentors take advantage of their mentees and that there is likely to be a power differential where the mentee may be vulnerable. Where there is no formalised mentoring relationship faculty members should look to peers and colleagues for informal mentoring.
162. These authors suggest that at institutional level mentoring should be formalised and recognised as a professional activity like any other. Academic institutions should increase the likelihood of successful mentoring relationships by bringing junior faculty members and potential mentors together in a systematic way early in the careers of new faculty members. They suggest that potential mentors and mentees should meet in social as well as professional settings to begin the networking process. They suggest there are several ways to facilitate these relationships without making assignments. The authors remark that mentoring relationships will evolve as both parties learn about one another but the outcome is uncertain. It is critical that the relationship should be regarded as 'no fault' and that either party has the option to terminate for good reason without risk or harm to careers. The authors suggest that formal visible systems for mentoring make the connections easier for the potential mentors and mentees. Institutions can encourage and reward mentors by publicly recognising their efforts as well as by scheduling formal time to the activity.

Assigned mentoring can be useful, but the environment must support the mentee in finding another mentor if the current one is not meeting his or her needs. Institutions should make women and minority mentors available to faculty members, but not assume that all mentees would prefer a mentor who is of the same gender or race.
163. In contrast to the traditional one-to-one relationship, authors⁹⁵ from Johns Hopkins Bayview Medical Center, Baltimore, suggest that a shared approach would help to

⁹³ Bauchner H. Mentoring clinical researchers. *Arch Dis Child* 2002;86:82-84

⁹⁴ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. 'Having the right chemistry': a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

⁹⁵ Levine RB, Herbert RS, Wright SM. The three-headed mentor: rethinking the classical construct. *Med Educ* 2003;37:486

overcome common barriers by increasing the total time available for mentoring, providing a broader range of skills and exposing mentees to multiple styles, perspectives and teaching philosophies. They developed a 'three-headed' approach to mentoring. A team comprising two general internal medicine fellows and a faculty member together mentored an intern and a third-year resident on two separate research projects over an 18 month period. Residents met with the entire team or with individual mentors depending on time constraint. The mentoring process had been reviewed prior to starting and strategies were discussed and goals were set. The mentors met periodically to debrief and reflect on ways to improve the model. Residents were asked to give feedback and the model was refined.

164. A qualitative analysis of the experience showed that both fellows wanted to gain experience in mentoring a junior physician on a research project and recognised they did not have the skills and resources to do so. The fellows wanted the opportunity to observe an experienced mentor and pick up tips in the process. The faculty mentor wanted to meet the goals of the residents by helping them to complete a successful research project. He wanted to role model important skills and behaviours critical to mentoring such as 'setting specific goals, being available and approachable, and responding promptly'. All three mentors were committed to observing one another and providing feedback. All believe that the approach was time saving, fun, effective (producing quality research) and resulted in greater reflection about the mentoring process. Both residents wanted to learn about conducting research and complete a successful project. They commented that the multiple mentor approach helped to model team work and communication skills. The residents valued meeting with the individual mentors but also wanted the whole research team to meet periodically. Based on the initial success of this intervention the authors state that there may be a role for expanding the mentoring relationship to include more than one mentor.
165. The idea of team mentoring is taken further in a theoretical model proposed in 2003 for academic pediatrics, based on the Nine Circles of Hell in Dante's Divine Comedy. The authors⁹⁶ from Case Western Reserve University, Cleveland, Ohio suggest that appropriate responses define the characteristics of good mentoring as knowing trainees' abilities and communicating clear expectations, defining the mentoring relationship, being certain that authorship for educational and research curricula reflects an appropriate level of involvement, providing appropriate and timely praise and criticism and promoting trainees' unique characteristics in career development.
166. The authors suggest that there is an ethical responsibility of faculty at all levels to designate a substantial amount of time to trainees' independent research and/or educational projects. They need to credit trainees by clearly identifying their efforts in data presentation and publications, active participation of mentoring faculty and trainees in institutional biomedical research ethics training programs, emphasising diversity in the recruitment of trainees and faculty, and using a team of mentors for each trainee to alleviate the burden of exclusive, potentially manipulative and/or destructive relationships.

⁹⁶ Drotar D, Avner ED. Critical choices in mentoring the next generation of academic pediatricians: nine circles of hell or salvation? *J Pediatr* 2003;142:1-2

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167. In their department, the authors have developed a program of mentoring committees which review junior faculty career planning and progress. This was based on the concept that a single mentor cannot meet all the faculty members' career development needs and is modelled on the format of a PhD dissertation committee. The roles of the committee are outlined in the paper. Finally
- to encourage the salvation of mentors and their trainees, we advocate a scholarly, ethics-based approach to mentoring including critical analyses of the abuses of mentoring as well as exemplars of competent and innovative mentoring.
- and
- Moreover, careful evaluation of the career development of trainees who have received different types of mentoring will facilitate comprehensive, evidence-based strategies for the future mentoring of academic pediatricians.
168. In contrast, a 2002 paper by Pololi and colleagues⁹⁷ gives details of a peer-group collaborative mentoring program (CMP). The authors state that most descriptions of mentoring and its benefits
- focus on a dyadic, mentor-protégé(e) model. The drawbacks of this traditional model include the limitations of a mentor's individual perspective and source of information, a lack of congruence in the expectations of mentor and protégé(e), personality clashes, transference issues, sexual dynamics, emotional or professional dependency, lack of consistency, passivity related to role modelling and lack of senior mentors with time available.
169. The goals of the program are set out as being: (1) create an environment of support and guidance for achieving career satisfaction and advancement, (2) foster in faculty increased awareness of their own career goals, personal values, strengths and priorities, (3) facilitate faculty in planning the methods by which success will be achieved in career and personal goals, (4) aid faculty in the development of requisite skills toward the achievement of career goals, (5) promote increased awareness of gender and power issues in relation to career goals, (6) facilitate faculty participants in becoming part of a collaborative and collegial team.
170. The 80 hour programme spanned eight months and comprised an initial three-day session followed by a full day programme once a month for six months. It was held in a setting outside the medical school and participants were provided with a manual with extensive readings, bibliographies and a career planning notebook. Each nine hour session combined skill development, structured career planning, and scholarly writing. Learning and teaching strategies were learner-centred experiential learning, role play, video taping, group discussion, extensive feedback from peers and facilitators, story telling or narrative writing, and self-reflection. Participants were 18 assistant professors representing eight clinical departments in 12 subspecialties.
171. The program was formally evaluated. Striking among the findings was that participants
- repeatedly identified their peers as 'collaborators; or 'colleagues' (implying a non-hierarchical relationship) rather than as 'mentors', even though the attributes they valued in their peers were consistent with the expectations of having a 'mentor': shared insights, experiences, ideas, guidance, problem solving, and support.

⁹⁷ Pololi LH, Knight SM, Dennis K, Frankel RM. Helping medical school faculty realise their dreams: an innovative collaborative mentoring program. *Acad Med* 2002;77:377-384

172. The authors contrast this with the problematic characteristics of senior-junior mentoring relationship such as power, dominance, dependency and transference. They also suggest that the CMP circumvents other difficulties in dyadic relationships, including lack of mentors' availability, inconsistency, and the limitations inherent in perceiving just one person's perspective. Data from the program suggest that faculty retention was linked to the programme content and learning environment.

6. How do authors describe the issues to be considered by a mentor?

173. The literature has been reviewed with a view to answering this question with particular reference to:
- What would be expected of me as a mentor? What qualities and skills do I need?
 - Mentor recruitment and selection
 - Developing, improving and maintaining skills: support for mentors
 - Recognition and career development

UK literature

174. Bligh⁹⁸ suggests that most mentoring is informal and invisible. He suggests that a major issue, however,
- is how to make professional support available for doctors where different types of advice are required at different times. Such a wide range of skills is required of a mentor under the current wide ranging definition, as to be almost unobtainable in one individual.
175. This latter point is echoed by Okereke and Naim⁹⁹.
- in reality, no one person has all the attributes of a 'good mentor' and mentees would be better served by a mentoring team rather like a supervising team instituted by some higher educational establishment for students undertaking postgraduate research.
176. Freeman¹⁰⁰ suggest that mentors are defined as professionally experienced and respected peers, prepared to set aside their own agenda and offer time and attention to the development of their mentee. Freeman¹⁰¹ suggests that
- a mentor supports their mentee through the process of transition – a journey from one state of being to another.
- and
- in mentoring, the quality of support offered by the mentor has to be deep enough, and brave enough, to support both the professional and the personal self of their mentee, not to make false divisions between the two dimensions in order to keep the mentoring relationship comfortable – making the task easier for the mentor, but short-changing the mentee. The mentor has to remain available and active throughout the process of transition, setting aside their own agenda and asking nothing in return from the mentee except that which accrues to them naturally through the experiences of becoming a mentor.
177. This author describes the role and function of a mentor as being 'holistic' implying an intervention that holds together continuing education, personal support and professional development. The ability of the mentor to move easily between these three elements is considered to be an essential component. Mentors use the reflective cycle to facilitate reflection on experiences in personal and professional

⁹⁸ Bligh J. Mentoring: an invisible support network. *Med Educ* 1999;33:2-3

⁹⁹ Okereke CD, Naim M. Mentoring senior house officers. Is there a role for middle grade doctors? *Emergency Medical Journal* 2001;18:259-262

¹⁰⁰ Freeman R. Towards effective mentoring in general practice. *Br J Gen Pract* 1997;47:457 – 460.

¹⁰¹ Freeman R. Faculty mentoring programmes. *Med Educ* 2000;34:507-508

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life, identifying factors inhibiting development. From this shared reflection, realistic and manageable goals for future development are set. Freeman makes particular note of

the fragile process of the opening interview.

178. According to this author, mentors can make a significant contribution to the professional development of general practitioners and can increase their sense of well being, provided certain criteria are met.

These include placing the activity within the established framework of professional development, adult learning and reflective practice. Structured, ongoing training and support for mentors is essential, as is an efficient, yet sensitive, administrative structure.

179. Alliot¹⁰² suggest that facilitatory mentors should be practising GPs whom the mentees are more likely to trust. Mentors require attributes such as understanding, a caring nature, enthusiasm and an ability to encourage reflection and constructive action.

Experience both of success and failure is also important as are up to date knowledge and clinical skills.

180. The main areas of gain for mentors are listed as: a sessional fee including travelling expenses (around £100), knowledge, skills and status. The disbenefits include frustration, strains and conflicts which can occur in any caring relationship. Alliot further suggests that a support group for mentors is important to help cope with emotions. It is also useful for sharing educational ideas, disseminating useful ideas and problem solving skills horizontally throughout the region. The paper emphasises the role of mentoring in stress reduction in both mentors and co-tutors.

181. In one programme reported by Challis and colleagues¹⁰³, in which a GP educator-mentor (also a practising GP) helped groups of GPs with their educational planning, the mentor is as much part of the learning group as other participants. The authors suggest that, although completing a learning cycle is now well established, its implementation is often difficult for learners who have been accustomed to having their learning needs dictated and met by others. Reflection, too, is often under-recognised or taken for granted. It was considered necessary to ensure that these concepts were fully understood and that support was available in planning areas for development, learning from reflection and building on identified learning. Such support was provided through the co-mentoring groups.

182. The GP educator-mentor is also engaged in preparing a portfolio but has expertise in educational development. These authors suggests that the mentor's role

in bringing together the group is to facilitate the sharing of ideas, hopes, anxieties and progress in learning, i.e. focussing on any topic that is considered important by any group member.

and

There is, therefore, little difference in professional status between the mentor and the mentees, which gives the whole mentoring process a degree of dynamic

¹⁰² Alliot R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

¹⁰³ Challis M, Mathers NJ, Howe AC, Field NJ. Portfolio based learning: continuing medical education for general practitioners – a mid-point evaluation. *Med Educ* 1997;31:22-26

interaction which goes beyond the role of mentor as 'expert' and the mentees as 'novices'.

and

GPs are willing and able to engage in a process of identifying and meeting their own learning needs by drawing up an educational plan using the process of reflection on current practice.

183. This process can be facilitated within co-mentoring groups in which no individual is seen as the 'expert'. The role of facilitator/mentor

is consistent with that of peer learner within a co-mentoring group, as long as the dual function of learner and assessor can be kept visible and distinct from each other.

184. Gupta and Lingam¹⁰⁴ suggest that mentors

need formal training on communication skills, the laws related to education and training (particularly involving the speciality in which the mentor is working), current immigration rules, GMC rules in relation to registration, performance procedures, self-regulation, etc.

185. According to these authors mentors help mentees to

- Establish themselves quickly in their learning and social environment.
- Gain knowledge and skills (particularly related to personal and social skills).
- Understand the working of the Royal Colleges, and their faculties, the NHS Trusts, British Medical Association (BMA), GMC, ODA etc.
- Develop personally.
- Acquire expertise in fields in which they need improvement.
- Understand appropriate behaviour in different situations.
- Understand different and conflicting ideas.
- Develop values and an ethical perspective.
- Adjust to change.
- Question their responses to certain issues, problems and situations.
- Overcome setbacks and obstacles
- Acquire an open, flexible attitude to learning.
- Enjoy the challenges of change.

US literature

186. Barr and colleagues¹⁰⁵ from radiology suggest that the protégé not only learns by instruction but also by observing the mentor in patient care, interactions with other physicians, and trainees and technical personnel.

The observed actions of the mentor are more effective than what is verbally imparted.

187. The authors suggest the mentor also acts as an advocate making the department chairman aware of the potential of the protégé. The mentor must be alert to situations which can favour the protégé and provide a network of support and future

¹⁰⁴ Gupta RC, Lingam SL. Mentoring for doctors and dentists. Oxford: Blackwell Science, 2000.

¹⁰⁵ Barr LL, Shaffer K, Valley K, Hillman BN. Mentoring. Applications for the practice of radiology. Investigative Radiology 1993;28:71-75

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opportunities. When appropriate the mentor is also involved in pointing out under-performance. The authors suggest that the rewards of mentoring are 'internal' but can help the mentor to appreciate his or her own role in the advancement of the specialty and through the success of the protégé being a mentor enhances the mentor's level of recognition within radiology.

188. The authors list barriers to mentoring which include mentor-protégé differences in terms of race, creed or sex and the inexperience of some who take on the mentor role because of self-doubt about their ability to fulfil the protégé's needs, environment and overwork and being professionally isolated, e.g. choosing to pursue basic science research in a clinically oriented department. Potential problems during the relationship include jealousy, sexual misconduct, lack of commitment from the protégé and they stress the importance of loyalty. The authors suggest that mentoring arrangements can be improved in departments by developing mentors, training them in mentoring techniques and assigning 'advisers' to new entrants until they can develop their own more effective relationships. Informal events should be planned to allow cross-gender mentor-protégé interaction and department chairmen might consider providing financial rewards for successful mentoring.
189. According to Barondess¹⁰⁶

mentoring, to be effective, requires of the mentor empathy, maturity, self-confidence, resourcefulness, and willingness to commit time and energy to another.
190. The relationship between being a mentor a good clinician and teacher is stressed by Benjamin¹⁰⁷

I would like to suggest that, as mentors, we demonstrate respect for patients and role-model good interactions with operating room and hospital staff. This requires that we are confident in our role as physician and teacher.
191. According to the 1997 consensus statement from the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine¹⁰⁸

Good mentors are able to share life experiences and wisdom, as well as technical expertise. They are *good listeners*, *good observers*, and *good problem-solvers*. They make an effort to know, accept, and respect the goals and interests of a student. In the end, they establish an environment in which the student's accomplishment is limited only by the extent of his or her talent.
192. In a 18-respondent questionnaire study from the Department of Family and Community Medicine, Milwaukee, the authors¹⁰⁹ sought to validate Daloz's mentor/protégé interaction model (Daloz LA. *Effective Teaching, Mentoring*. San Francisco CA: Jossey-Bass, 1986) which balances three key elements, support, challenge and a vision of the protégé's future career. Each protégé was assigned to a

¹⁰⁶ Barondess JA. On mentoring. *J R Soc Med* 1997;90:347-349

¹⁰⁷ Benjamin JB. Mentoring and the art of medicine. *J. Trauma, Injury, Infection and Critical Care* 1998;45:857-861

¹⁰⁸ Adviser, Teacher, Role Model, Friend: On being a mentor to students in science and engineering. Washington, D.C.: National Academy Press, 1997 and at <http://www.nap.edu/readingroom/books/mentor/>

¹⁰⁹ Bower DJ, Diehr S, Morzinski JA, Simpson DE. Support-challenge-vision: a model for faculty mentoring. *Medical Teacher* 1998;20:595-597

senior departmental faculty mentor who had had no previous experience mentoring in a formal program but who did attend a one-hour orientation session where program goals and associated mentor/protégé discussion topics were presented. A three-part protégé questionnaire based on the characteristics of effective mentors was developed. Two parts were quantitative and one was qualitative. Nine respondents would recommend their mentor to another junior faculty (high recommending group); the other nine would not recommend their mentor or had reservations (low recommending group).

193. They found that eight out of 13 specific mentor roles were rated significantly higher by a group of protégés who would recommend their mentor compared to a second group of protégés who would not. The roles were
 - serving as a source of support and a source of challenge; providing insights on ‘who I am’ and ‘where I am going’; being a role model, an advisor for professional development, an experienced guide, a teacher, and an information source.
194. Five other roles (sponsor for career opportunity, protector, source of collaboration, provider of sense of continuity and provider of climate for expectations) were not rated highly by either group. The low recommending group indicated in the narratives that mentors did little more than just give ‘feeling that I was doing OK’ or served as ‘sounding board for ideas.’ Other low recommended mentors were described as ‘challenging but distant’ or ‘friendly but did not provide useful insights’. The low recommending group wished that mentors would ‘challenge me’ or would be ‘more critically productive’, indicating the need for higher challenge or they indicated the need for higher support. In contrast the high recommending group indicated that their mentors had provided challenge and stronger levels of support through ‘setting clear goals’, ‘providing positive expectations’, ‘providing opportunities to meet othersto participate in a project’, and ‘knowing me as a person.’ This group also showed evidence that vision of their future was fostered.
195. The authors conclude that
 - Highly recommended mentors balance significant levels of challenge and support. HR mentors actively support protégés with structure, opportunities and by setting positive expectations. HR mentors also challenge through setting tasks, actively engaging in discussion, articulating incongruence between values/goals and actions, and setting high standards. They also foster vision through role modelling and stimulating self and future awareness
196. The importance of challenge is a theme also highlighted by Souba¹¹⁰ who points to a number of elements to this process including the parachute role which involves creating a secure environment where the mentee can begin to explore new paradigms without the fear of falling; the free fall role – ‘stretching’ the mentee. The author suggests that challenging the mentee forces him to step out of his zone of comfort (where there is predictability and minimal risk but limited potential for new growth) into the zone of discomfort (where there is conflict and greater uncertainty but the potential for growth and new learning). The next element is the balance act which represents the extent to which the young mentee is supported or stretched – a judgement which the mentor must exercise.
197. Souba also suggests that

¹¹⁰ Souba WW. The essence of mentoring in academic surgery. *J Surg Oncol* 2000;75:75 – 79
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Mentors are individuals we look up to who have attained the kind of goals that we hope to achieve – they offer us support and advice. If they appear to be magicians, it is because of the wisdom and discernment they possess.

and

In academic surgery, mentors assist the residents in becoming competent and developing independence and they coach junior faculty as they move up the academic ladder. They help us by removing political and other barriers along the way, providing advice about which path to take, and running interference when the road gets rocky.

and

Sometimes the emphasis is on providing a compass for smoothing out the trail rather than on developing the trainee. It may be more convenient to supply the answers and show the way (particularly when the mentor is familiar with the landscape) rather than take the extra time so the young person can learn from his mistakes and in the process develop the necessary skills to navigate new territories that are likely to be full of surprises.

and

A good mentor, therefore, will be much more of a trainer and a teacher than an usher or escort. The idea of mentor as a nursemaid is inaccurate and ludicrous – transferring a unit of knowledge to be downloaded into a mental database is less important than the impact of that knowledge on the mentee's growth and self-development. The goal is to develop a Jedi warrior who can successfully confront new challenges and overcome unanticipated obstacles rather than a chauffeur who only knows one way of getting from point A to point B.

198. The paper goes on to consider the range of mentor roles from counselling through teaching and coaching to being a friend or an agent. The author suggests that all these roles can be assigned to mentor.
199. Souba further suggests that mentoring effectiveness hinges on three components: the mentor's knowledge, his actions and his core values. To cultivate the growth and development of their mentees, mentors must know how to listen, when to provide advice, when to back off, and how to shine in reflected light. Good mentors must also be able to translate what they know into action. They must provide resources, give of their time and run interference when necessary. He also concludes by describing mentoring as a commitment suggesting
rather than the mere transmission of facts and knowledge, the central element is the attention and nurturing provided to the individual.
200. Larkin¹¹¹ has likened the mentor to
... a vocational midwife or trainer that will help students find themselves in the forest of modern medicine, and through this coaching relationship, trainees may ultimately embrace professionalism through discernment of personal mission or calling. In academic medicine, that may mean a calling to research, education, clinical operations, or administration, but in every case, the mentor will help the peg - square, round, or oval - find its matching hole. The conversation of mentor and student is necessarily broad, but it informs the notion of finding one's place in the cosmos of profession in a life-affirming and powerful way.

¹¹¹ Larkin GL. Mapping, modeling, and mentoring: charting a course for professionalism in graduate medical education. *Cambridge Quarterly of Healthcare Ethics*. 2003;12:167-177

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201. Bauchner¹¹² suggests that the formal mentor-mentee relationship requires commitment and an agreement on basic principles. Time commitment is an essential ingredient both on a regular and ad hoc basis. The responsibilities of the mentor include: (1) being available, (2) acting as an advocate for the mentee, (3) insisting on completion of projects, (4) assisting with networking and (5) seeking extramural funding.
202. From the standpoint of academic radiology, Illes and colleagues¹¹³ suggest that Consistent with the evolving academic skills of those being mentored, mentors in medicine must bring to the relationship (a) a personal element that encourages confidence and creativity in the mentored person, (b) a functional element that deals with pragmatic aspects of professional activity, and (c) a developmental element that focuses on interpersonal skills and networking. These overlapping themes are clearly relevant in the context of any mentoring relationship in which the goal is to cultivate the successful careers of individuals and future leaders of academic medical subspecialties. Clearly two of the most important elements of any mentoring partnership are the acceptance of the need to mentor and to be mentored and the willingness to teach and to learn.
203. In the qualitative study by Jackson and colleagues¹¹⁴, participants reported the importance of responsiveness and availability in a mentor. They value mentors who are knowledgeable and well respected in their field. An effective mentor values mentoring as an important part of his or her professional role and is dedicated to developing an important relationship with the mentee.
204. In a 2000 paper from psychiatry, Rodenhauer and colleagues¹¹⁵ from Tulane University School, the Department of Family Medicine, Wright State University School of Medicine and Harvard Medical School cite Darling (Darling L. What do nurses want in a mentor? *Journal Nurs Adm* 1984; 14: 42-44) who suggested three basic requirements of a mentoring relationship are attraction, affect and action. The mentor must recognise the qualities in the protégé he wants to develop and the protégé needs not only to admire the mentor and his or her accomplishments but also possess a strong wish to emulate him or her.
- and
- Although the mutual expectations within the mentor-protégé relationship might not always be explicit, a commitment to mutually agreed-upon objectives, a willingness to learn under the mentor's supervision, devotion of the necessary time and energy to the agreed-upon goals and an expectation that the protégé become increasingly independent are sine qua nons.
205. They cite Ricer and colleagues (Ricer RE, Fox BC, Miller KE. Mentoring for medical students interested in family practice. *Family Med.* 1995; 27: 360- 365) as saying

¹¹² Bauchner H. Mentoring clinical researchers. *Arch Dis Child* 2002;86:82-84

¹¹³ Illes J, Gover GH, Wexler L, Leong ANC, Glazer GM. A model for faculty mentoring in academic radiology. *Acad Radiol* 2000;7:717-724

¹¹⁴ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. 'Having the right chemistry': a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

¹¹⁵ Rodenhauer P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

the tasks of mentoring are of less importance than the personal characteristics of the mentor.

206. Bhagia and Tinsley¹¹⁶ from Fairmont Clinic, Mayo Health System, Fairmont, Minneapolis, and the Department of Psychiatry and Psychology, Mayo Clinic, Rochester, Minneapolis, emphasise in their 2000 paper that mentoring is a partnership with responsibilities on both sides. They state that the three basic tasks of the mentor have been described as to inspire, to support and to invest and in a table they list the commonly recognised characteristics and skills of the good mentor. Support may be emotional, practical and as an investor, the mentor pushes the student, draws out his or her capabilities and demonstrates trust by putting the student in charge.
207. According to these authors, other important duties of the mentor are to pass information, to be confident enough to admit ignorance and to work with a student to find answers to questions. Effective mentors are skilled in asking questions that provoke critical thinking, analysis, and reasoning. The mentor also needs to provide security by making the mentored person a part of the system and by initiating social interactions that promote trust and a sense of warmth.
- When mentors share feelings and experiences about their professional lives, they give a valuable gift of professional inclusion.
208. Citing Kram (Kram, K.E. *Mentoring at work: developmental relationships in organisational life*. Glenview, Ill.: Scott, Foresman; 1985) these authors suggest that interactions that occur in a mentoring relationship can be divided into broad categories of career function and psychologic functions. Psychosocial functions facilitate a sense of competence, identity, and effectiveness in the professional role. The authors state that spontaneous or accidental mentoring almost always works. Although the utility of planned mentoring has been questioned, they cite Morzinski and colleagues (Morzinski JA, Diehr S, Bower DJ, Simpson DE. A descriptive cross- study of formal mentoring for faculty. *Family Medicine*. 1996; 11:175-180) to show that planned formal mentoring programs can have a moderate – high effect on the development of professional academic skills by students. The authors suggest that the more the mentor and student interact, the more likely a meaningful relationship will develop. Outside activities, such as shared meals, sports and interests in professional societies may help foster relationships. But the authors warn that a relationship that ‘deviates into sexual territory’ is no longer a mentoring partnership because the primary goal becomes personal rather than professional.
209. This paper also considers ending the mentoring relationship which they describe as either ‘planned separation’ or ‘sudden loss’.
210. Barr and colleagues emphasise the commitment to a long term relationship. Citing Kram, K.E. (Phases of the mentor relationship. *Academy of Management Journal*, 1983;26:608-25) the authors outline the four consecutive stages of mentoring, the first being an initiation stage lasting up to 12 months. The next phase is the protégé stage which lasts two – five years. The third phase is the break up and the final phase is lasting friendship and a strong peer-peer relationship. The authors suggest that there are a number of pitfalls that may lead to career mediocrity and avoidance of these can be assisted by mentoring. They suggest, however,

¹¹⁶ Bhagia J, Tinsley JA. The mentoring partnership. *Mayo Clin.Proc* 2000;75:535-537

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before one can enter into a successful mentoring relationship, it is important to prioritise professional and personal goals.

7. How do authors describe the issues that doctors need to consider before accepting a mentor?

211. In this section the literature has been examined with a view to answering this question with particular reference to:
- What would be expected of me as a mentee?
 - Will it work for me?
 - Should I accept an allocated mentor? How do I choose a mentor?
 - Can I trust a mentor?
 - Should I have only one mentor?
 - What do I do if I don't find my mentor helpful or if there are other problems?
212. Much of the material in previous sections on benefits and on mentor expectations, requirements and roles is clearly relevant to mentees' understanding of the process. The UK literature is overall not very forthcoming specifically on mentee roles, contributions and characteristics.
213. Gupta and Lingam¹¹⁷ suggest that
- People learn how to be a mentee through being part of a mentoring relationship. With experience and practice you will become better at making the most of the mentoring process.
- and
- Successful mentees accept challenges willingly. They are committed to the mentoring process.
- and
- Mentees must be willing to be active in their development and to see learning as a continuing process. When the mentee owns the process the quality of learning is improved, and this is a clinical governance issue for all doctors. Active mentees make progress faster and will become better doctors.
- and
- The mentor will help you to 'develop under your own power'. The mentee will be more willing to take risks when an atmosphere of mutual trust and respect exists. This is achieved through open discussion and regular contact.
214. They suggest that mentees expect to
- be challenged
 - be coached
 - develop greater self-confidence
 - be supported and encouraged
 - be assisted in developing their careers
 - become more self-aware.
215. In a study of 68 GP mentees working with 25 GP mentors, Freeman¹¹⁸ reports that support, independent advice and career guidance were common mentee expectations

¹¹⁷ Gupta RC, Lingam SL. Mentoring for doctors and dentists. Oxford: Blackwell Science, 2000.

¹¹⁸ Freeman R. Towards effective mentoring in general practice. Br J Gen Pract 1997;47:457-460

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The most important factor was the independence and neutrality of the mentor. The author suggests that this supports the decision to allocate mentors on a neutral basis with mentor and mentee unknown to each other. An unexpected development was the ability to change. Alongside this was the 'feel good' factor that came from being listened to and supported.

216. The main themes that took place in mentor-mentee discussions were career development both in terms of planning the future and routes to achieve it. The personal feedback obtained from a mentor was appreciated. In particular, in sharing the distress that arises from dysfunctional relationships with partners, mentees sought feedback on how they might handle their role more effectively. In terms of personal support, mentees most frequently sought help in managing boundaries between work and professional life and devising coping strategies for stress. In terms of outcomes of mentoring, the strongest theme was

achieving change through the medium of a reflective, supportive mentor relationship, resulting in changed perspectives and a re-ordering of priorities.

and

the continuous, supportive nature of the mentoring relationship enables mentees to achieve a more robust professional identity, empowering them to take control, rationalise pressures and formulate and implement change in their working lives.

217. In a 2002 paper, Grainger¹¹⁹ advises

The key to choosing a mentor is first deciding what you want to achieve and whether mentoring is the most appropriate way to achieve it. If you want to increase your knowledge then reading or courses may be better ways of achieving your learning goals than using a mentor.

218. This author suggests mentors are chosen on the basis of personal characteristics or because of some particular achievement, sometimes made in the face of disadvantage. Further,

Mentoring should stretch you, move you out of your current comfort zone. Seeking out someone who thinks in the same way as you may not challenge your ways of thinking and working sufficiently to accomplish this.

Practicalities in a mentoring relationship are also important. How far are you willing to travel? How often do you wish to meet? How long are the meetings? How long do you wish a mentoring contract to continue? A mentoring relationship can be very intimate, and, although a mentor does not have to be a friend, he or she does need to be someone that you can relate to.

219. The author further advises

Having decided on the type of mentor you would like, you then have to find someone who meets your specification. Good starting points are to ask line managers and use your own networks to identify someone suitable. Beware of using mentors in your organisation, as this can be seen as underhand ways of achieving power, influence, promotion, or going above your boss.

The next step is to arrange a meeting with your proposed mentor to test the water. Here you will be looking at whether you can relate to this person, whether he or she is willing to act as a mentor, and whether the practicalities can be accommodated.

¹¹⁹ Grainger C. Mentoring – supporting doctors at work and play. *BMJ* 2002;324:S203.

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220. The issue of ‘was it all worthwhile?’ from the mentee’s point of view is clearly important. Grainger advises

It is important to evaluate a mentoring relationship. Think about:

- Process - were there clear objectives? Did you have regular, purposeful meetings?
- Communication - did the mentor give honest feedback? Could the mentee raise issues for discussion?
- Outcome - is there a sense of progress and development? Have others noticed a change in the mentee? Has your mentor helped you to network?

Finally, there is the question of whether or not a mentoring relationship should continue. For many people mentoring may be a fairly short relationship in which the mentee wishes to focus on a particular topic, and once that issue has been addressed, the mentee's development needs are different and can no longer be met by the same mentor. This change of role, and therefore change of mentor, is common and entirely acceptable. The relationship focuses on the needs of the mentee and the most appropriate way to meet them.

Sometimes, however, a long term relationship is appropriate, but often one that will vary in intensity. In this instance the mentee may identify a good mentor, work with them intensively around a given issue, and then simply keep in touch for a while, until another issue comes up that requires more intensive support.

There is no right or wrong way of using a mentor, just the way that suits the mentee best.

US literature

221. The 1993 paper from Barr and colleagues¹²⁰ sets out a mentee self-assessment table and suggests what qualities mentees should look for in a potential mentor. The authors suggest that the mentee should carefully review the career record of each potential mentor before pursuing the relationship. Quoting Ragins and McFarland (Ragins, B.R., McFarland, B. Perceptions of mentor roles in cross gender mentoring relationships. *Journal of Vocational Behaviour*. 1990; 37: 321-339) they further suggest that

protégés without prior formal mentoring experience tend to expect more from the first mentor than those who have had several mentors.

222. In a 1996 survey of fellows in geriatric medicine attending a convention, Johnson and Valle¹²¹ found that fellows most often selected a professor as a mentor. Female fellows might be more likely than male fellows to list a female mentor. The majority of fellows listed relationship characteristic and personal attributes as essential qualities of a mentor. Relationship characteristics included ‘time’, ‘guide/offer direction’ and mentors’ personal attributes included ‘enthusiasm for the field’, ‘listener’ and ‘patience’.

¹²⁰ Barr LL, Shaffer K, Valley K, Hillman BN. Mentoring. Applications for the practice of radiology. *Investigative Radiology* 1993;28:71-75

¹²¹ Johnson, T.M. Valle, G. Mentoring in the growth and development of the geriatric fellow. *J Am Geriatr Soc* 1996. 44:1486-7

223. In a 1997 paper reporting the results of a survey of postdoctoral research fellows in obstetrics and gynaecology, Dudley¹²² from Salt Lake City, Utah warns
- A few fellows have had problems with their mentors. These difficulties usually involve "ownership" of data or developing independence from the mentor's laboratory and field of research. Obviously, a critical need for the fellow submitting a grant is sufficient preliminary data. If the mentor claims these data, the fellow is left with little to show as he or she attempts to develop a research program. Academic promotion in the tenure track often is contingent on the concept of developing an independent research program. Therefore selection of the proper mentor is critical so that data are "owned" by the fellow and the mentor feels no threat regarding any fellow developing an independent program. One suggestion is to have the prospective mentor sign a "contract" that explicitly lists the expectations of the program and elicits a promise that the mentor will ultimately help the fellow work toward independence.
224. When choosing a surgical mentor Souba¹²³ (citing Souba WW, Gamelli RL, Lorber MI, et al. Strategies for success in academic surgery. *Surgery* 1995;117:90 [no final page number given]) advocates that the resident should take on board both the qualities of the mentor and the research environment
- a great mentor alone will not guarantee academic success, neither will a stellar laboratory without leadership.
225. The author mentions that in his laboratory there are several full-time scientists who play a crucial role in teaching the surgical residents how to design studies, master techniques, interpret results and write a manuscript. The author advocates peer mentoring as opposed to hierarchical mentoring as a means of compensating for the enormous time constraints that many senior mentors are subjected to (citing Kram, KE, Hall T. Mentoring in a context of diversity and turbulence in EE Koosek and SA Lobel (eds). *Managing diversity: human resources strategies for transforming the workplace*. San Francisco, CA: Blackwell, 1996).
226. The author further says that there are no hard and fast rules that guarantee success in selecting a mentor but there are some guidelines. The first question relates to 'what do I hope to gain from the mentoring experience?' suggesting that there are a number of possible goals and a variety of answers. Although traditional indices should be considered when choosing a laboratory, the resident should look for an experience where he can take another step in self-actualisation. The second question is 'what is the mentor's track record? What's the word on the street?'
227. The next section of this paper deals with the dividends of mentoring which traditionally has been seen to flow towards the mentoree. However, the author states that mentoring works best when it is a true partnership.
- Although the mentor as a rule has greater experience, insights and wisdom, every relationship provides an opportunity to grow and to improve mentoring skills.
228. According to Bhagia and Tinsley¹²⁴ mentees have an important part to play in finding a mentor.

¹²² Dudley DJ. Optimism for perilous times: a survey of American Association of Obstetricians and Gynecologist Foundation and Reproductive Scientist Development Program postdoctoral research fellows. *Am J Obstet Gynaecol* 1997;176:814-8

¹²³ Souba WW. Mentoring young academic surgeons, our most precious asset. *J Surg Res* 1999;82:113-120

¹²⁴ Bhagia J, Tinsley JA. The mentoring partnership. *Mayo Clin.Proc* 2000;75:535-537

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Students with ambition, ability and mentor-attracting skills seem most likely to acquire a mentor of high quality. Persons who engage in active behaviours that initiate mentoring receive more mentoring.

229. Further details of mentor seeking behaviour are given. They include searching for someone with similar interests and a compatible personality, expressing career goals, discussing specific areas in which help is needed, and demonstrating seriousness about one's career. The mentoring partners need not always agree; however, trust and respect are inherent in an effective partnership. Part of this respect is recognition that the mentor is investing his or her time and energy.
230. The paper by Rodenhauer and colleagues¹²⁵ distinguishes the skills necessary to enhance the initiation of the mentor relationship from the skills necessary to enhance the maintenance of the mentor relationship. The authors make reference to mentors who tend to choose protégés who remind them of themselves and protégés who choose mentors on a similar basis or who they want to become. In formalised mentor relationship programmes, in which mentors are assigned, the personal attributes and skills of the protégé become less important. The authors quote Barr and colleagues who recommend factors on which protégés may base their selection including the achievement record of the mentor, high standards, respect for the mentor in various networks locally, nationally and internationally, the mentor having faith in the protégé, the mentor understanding the protégé's needs (both personal and professional), the mentor being perceptive and honest to recognise when they cannot provide the protégé with necessary information and, in this case, the mentor helping the protégé to find someone else. The authors mention relationships in which the mentor initiates the relationship and in which the protégé initiates the relationship. Various techniques are mentioned.
231. The paper cites Fagenson (Fagenson EA. Mentoring: who needs it? A comparison of protégés' and non-protégés' need for power, achievement, affiliation, and autonomy. *Journal of Vocational Behaviour* 1992;41:48-60) who showed that high achievement and power orientated protégés are more likely to secure mentor relationships than their less driven counterparts.
232. The authors cite other papers which show the role of protégé personality in gaining mentors in a business setting, including well developed social skills, such as networking and social boldness, showing interest and promise, marketing and self promotion skills, and a capacity to form a deep and enduring bond with another person. The authors state
- the problem with the informality of the selection process involved in mentoring is that many young professionals who could benefit from mentoring do not find a mentor. Can the protégé skills needed to initiate and maintain a mentoring relationship be taught and, if so, should they be?
233. The authors also suggest that
- some protégés assigned to mentors may not be developmentally prepared for a mentoring relationship.
234. They cite Noe (Noe RA. An investigation of the determinants of successful assigned mentoring relationship. *Personnel Psychology* 1988;41:457-479) who has suggested

¹²⁵ Rodenhauer P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

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that 'a readiness for mentoring' measure be used to select for participation in mentoring programs those who are most likely to benefit from the experience. In the next section of the paper, the authors deal with the skills enhancing the maintenance of the mentor relationship. They emphasise that protégés are

mutually responsible for building rapport with mentors, observing and modelling their mentors' desired characteristics, actively listening, extending their analytical skills, doing their homework and being prepared, and communicating clearly and effectively in order to cope effectively with conflict in the relationship.

235. They list maintenance skills including the capacities for self disclosure, emotional availability, authenticity, empathy, and emotional vulnerability; the ability to accept and value differences; the ability to disagree with negative consequences; judgement in risk taking; and the ability to be personal. Persistence as a character trait is required. In Noe's study time limitations, incompatible work schedules and physical distance were the most frequently mentioned reasons for lack of interaction. Other issues that protégés may need to deal with include sibling rivalry, resentment and jealousy, alienation from the organisation, guilt at not entering wholeheartedly into the mentoring relationship.
236. The authors list the protégé behaviours that maintain the mentoring relationship as: being teachable and open, making oneself vulnerable by expressing needs for the mentor to fill, asking questions, temporarily accepting a 'one down' role, and showing interesting in and trying to please the mentor.

Protégés must be able to show the combination of compliance and challenge appropriate to their mentor. Too much compliance deprives the mentor of stimulation, and too much challenge is disruptive and may be irritating to the mentor.
237. Bauchner¹²⁶ outlines the responsibilities of the mentee which includes time commitment and also seeking out and being willing to hear criticism, and completing work. The author advocates that mentees should foster relationships with more than one mentor. Dilemmas in the relationship include reducing mentor availability as mentors become busier in their own careers, attending to their own careers, avoiding mentee abuse in terms of authorship, and acknowledging that relationships change with time. He suggests that in finding an appropriate mentor it is important first to identify what the mentee is searching for and not to confine research activities to own division, department or even institution. Prospective mentors and mentees should meet to discuss goals and expectations. The author concludes that

we need more clarity and activism around the mentor-mentee relationship in order to ensure success.
238. In a study based on 16 interviews, Jackson and colleagues¹²⁷ report that protégés do the work of finding a suitable mentor. Successful relationships can come together informally or from formal assigned mentoring relationships. Participants in the study suggest various ways of finding a mentor. These include setting up an interview with each faculty member. Persistence is also necessary and finding the right mentor match can be difficult. Finding a mentoring relationship that works for

¹²⁶ Bauchner H. Mentoring clinical researchers. *Arch Dis Child* 2002;86:82-84

¹²⁷ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. 'Having the right chemistry': a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

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both parties requires patience and perseverance. Mentees may find that many people, rather than one person, fill the mentoring role. The relationship between a mentor and a mentee can be complex. The relationship tends to flourish when both parties share similar interests and ideals. Participants repeatedly emphasise the importance of ‘chemistry’ in the relationship. This interpersonal aspect of the mentoring relationship is critical and can be especially problematic in programs that assign mentoring pairs.

239. The authors comment in the discussion that their study has begun to uncover the complexity of the mentoring relationship in academe today. This starts from finding an appropriate mentor to the skills a mentor must possess and then creating and sustaining a successful relationship. ‘Having the right chemistry’ appears to be essential and as such, a successful mentoring relationship requires the mentor and mentee to know about their respective working, communication, and relation of styles. Mentees may need to experiment with many different potential mentors to find the right match.

The authors derive some recommendations under two main headings (a) for the individual and (b) for institutions (see later). For the individual they suggest that faculty members must be diligent in seeking out a mentor and be explicitly aware of the personal and professional qualities they value and discuss these to find the right match. They should be alert to the fact that a few mentors take advantage of their mentees and that there is likely to be a power differential where the mentee may be vulnerable. Where there is no formalised mentoring relationship faculty members should look to peers and colleagues for informal mentoring.

240. Mentees perhaps should also be aware that the objectives of organisations and faculty members in terms of their professional development may be rather different, as was mentioned earlier in this document. In a paper from University of Massachusetts Medical School, Worcester, Massachusetts, and North Carolina and from Brodie School of Medicine at East Carolina University, Greenville, the authors¹²⁸ conducted an assessment of need for faculty development and mentoring in a medical school to guide program planning and use of scarce resources. The background to this study was the increasingly heavy focus on clinical practice and economic pressures in health care both of which have resulted in less time being allocated per clinical encounter and less time for teaching and mentoring of medical students and residents, which has become a hindrance to ‘clinical income expectations’. In the authors’ view this means that it is now more essential to encourage and support vitality and learning of the physician faculty. These negative influences may also, they suggest, account for high faculty turnover rates.
241. The senior administrators interviewed in the study identified key themes, including the need for faculty development programs, to foster quality in patient care and teaching, team work, internal motivation, global thinking, management and leadership skills, commitment of the institution and time management.’
242. However, the results of the needs assessment questionnaire to faculty members (72 per cent response) showed that the most highly prioritised needs were for (1) retaining their own values, (2) maintaining their academic vitality and (3) balancing personal and professional demands. In the discussion, the authors highlight the

¹²⁸ Pololi LH, Dennis K, Winn GM, Mitchell J. A needs assessment of medical school faculty: caring for the caretakers. *Journal of Continuing Education in the Health Professions* 2003;23:21-29

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degree of disparity between the perceptions of senior faculty and of senior administrators regarding priorities for faculty development. The institutional perspective on faculty development priorities seems to be one of commitment to the organisation, job skill development and time management, whereas the faculty prioritised renewal, sustaining their vitality, balancing personal and professional lives, finding meaning in their work, relationships and personal growth. The authors suggest this disparity may contribute to the attrition occurring in academic medicine and suggest the need for improved communication at all levels. They conclude

we interpret the findings of our investigation as a call by our faculty to become part of a community in learning in which, individually, they can find support and encouragement for the personal and professional growth and in which they can express confusion and vulnerability without fear of humiliation or reprisal.

243. The authors have responded to this by integrating these themes into their faculty development year-long courses on teaching skills and career development. Sessions in the program include experiential learning on values clarification, personal and professional balance, congruence between personal and institutional goals and time management. The theme of mentoring has been developed in a longitudinal mentor training program which provides two forms of mentoring for junior faculty through a facilitated collaborative peer mentoring program and a more traditional dyadic mentoring model.
244. A number of authors refer to the benefits to junior faculty members of having more than one informal mentor. The paper from Johns Hopkins Bayview Medical Center, Baltimore¹²⁹, mentioned earlier, suggests that formal schemes too can provide more than one mentor to individual residents. In this scheme a team comprising two general internal medicine fellows and a faculty member mentored an intern and a third year resident on two separate research projects over an 18 month period. Residents met with the entire team or with individual mentors depending on time constraint. A qualitative analysis of the experience showed that all three mentors were committed to observing one another and providing feedback. Both fellows wanted to gain experience in mentoring a junior physician on a research project and recognised they did not have the skills and resources to do so. The fellows wanted the opportunity to observe an experienced mentor and pick up tips in the process. The faculty mentor wanted to meet the goals of the residents by helping them to complete a successful research project. He wanted to role model important skills and behaviours critical to mentoring such as
- setting specific goals, being available and approachable, and responding promptly.
245. All believed that the approach was time saving, fun, effective (producing quality research) and resulted in greater reflection about the mentoring process. Both residents wanted to learn about conducting research and complete a successful project. They commented that the multiple mentor approach helped to model team work and communication skills. The residents valued meeting with the individual mentors but also wanted the whole research team to meet periodically. Based on the initial success of this intervention the authors state that there may be a role for expanding the mentoring relationship to include more than one mentor. This gives

¹²⁹ Levine RB, Herbert RS, Wright SM. The three-headed mentor: rethinking the classical construct. *Med Educ* 2003;37:486

greater opportunity for the residents to meet with mentors and allows mentors to share the experience and learn mentoring skills from each other.

246. Choice of mentors is another important issue. As noted earlier, the US literature has many references to gender and ethnic issues. Earlier literature states that women mentors may be in short supply. Weilepp¹³⁰ from Cornell University Medical College quoting other leading opinions suggests that one of the problems is that women do not see other women in leadership roles. Often it is male mentors who guide female students. The author cites Ochberg (Ochberg R, Barton GM, West AN. Women physicians and their mentors. *Journal of the American Medical Women's Association* 1989;44:123-126) and states that institutional rank, independent of gender, determined the effectiveness of a mentor. In a survey of the American Medical Women's Association, members assessed the mentor's role in several categories, including their boosting career promotion through strategic introductions, providing research and teaching opportunities, and counseling about behind-of-the-scenes politics. This study also found that mentoring relationships among females are less problematic than between male mentors and female students. The female mentors offered more personal advice to females than did male mentors. The study concluded that the opportunities available to female protégés would increase if medical schools promoted more women to authority positions. Quoting Bainton (reference missing from copy of paper or may be no reference given), Weilepp states that

Bainton observes that many women are not getting the coaching, research experience, and guidance needed to obtain grants.

247. Weilepp quotes Francesca Thompson who states that women have been their worst enemies by 'buying into their cultural stereotypes' and acceding to their own perceived limitations on their potential for combined family and career success. She observes

the greatest obstacle facing women in surgery today is their own dwarfed and outdated image of what they can accomplish professionally.

248. Ten years after the Weilepp paper, Linney¹³¹ suggests that some women want informal relationships and detest the word 'mentoring'. Others want formal programs established by big organisations identifying female stars and pushing them to the top as quickly as possible. The author suggests that

some women are hesitant to ask others to be mentors because they don't want to be turned down.

249. Linney suggests that sometimes a request for help can be a one-time event with no obligations but occasionally a friendship will evolve. Further, some preliminary work is necessary before an approach to a mentor is made perhaps, suggesting a number of options for the mentor to consider. The author also suggests that the mentee should be polite, not overstep the bounds of proper etiquette suggesting that the mentor is not responsible for getting the person promotion. Rather her function is to be a coach and guide in career and life development so that the mentee is prepared to benefit from opportunities when they present themselves. The author

¹³⁰ Weilepp AE. Female mentors in short supply. *JAMA* 1992;267:739-742

¹³¹ Linney BJ. Mentoring: women learning from others. *Physician Exex* 2002;26:72-76

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suggests that the prospective mentee should think carefully about whom to approach and use time wisely.

250. Under the heading ‘advantages of having women mentors’ the author quotes a number of women who have benefited from such a relationship but quotes one as saying

while mentors can be helpful, the best way for women to advance is to look around, learn from everyone with whom they work, develop their strengths and build on what they learn ... Mentoring is helping and you are surrounded by people who can help.

251. **The author concludes**

whether you like the word ‘mentoring’ or not, whether your organisation has a formal program or not, always be thinking about how you can learn from others. Keep your eyes and mind open, look around to see who is doing what you want to do. Pay attention to people you envy or think you are falling in love with. They may have a quality you already have but are afraid to risk using.

8. How do authors describe the issues to be considered by scheme organisers?

252. In this section the literature has been examined with a view to answering this question with particular reference to:
- What would be expected of a scheme organiser or advocate?
 - Cultural issues – the place of mentorship in the organisation
 - The importance of mentor development programmes, their impact on mentoring schemes and choice of providers
 - Matching mentees and mentors
 - Getting the relationship going
 - Supporting mentors
 - Resources for mentoring.

UK literature

253. Possibly because there are, as yet, few accounts or evaluations of UK schemes in the published literature it is hard to find much comparative guidance on these issues.
254. Alliot¹³² reports that GP mentors spend about half or one day a week seeing mentees and receive a sessional fee of around £100 (including travel expenses). He mentions that as a GP mentor may see more than one GP from a practice that there can be confidentiality conflicts. He suggest that
- the mentor support group has been invaluable in giving support and guidance when these problems occur.
255. In addition
- Dealing with mentees' personal issues can be stressful. We have found that our support group of mentors extremely important in helping us cope with these emotions. The group is also important for sharing educational ideas and acts as a powerful means for disseminating useful ideas and problem solving skills horizontally throughout the region.
256. Eastaugh and colleagues¹³³ state that in the Anglia GP co-tutoring scheme follow-up workshops are provided for support and encouragement and to enhance and develop skills. The wider support and stimulation offered by the sessions was seen as at least as important as the co-tutoring itself.
257. The role of the facilitators of these workshops is seen as being crucial.
- We have found that two facilitators are essential in order to support each other and help to model the co-tutoring process. Setting up and facilitating the courses requires specific skills and experiences. Co-tutoring requires openness and a preparedness to share vulnerability: so facilitators must be able to be honest about themselves and their own experience. Perhaps most crucially the facilitators must have the ability to create and maintain safety for the participants without removing the challenge of pushing out the comfort zones. Inevitably during workshops and working in small groups participants may discover areas of

¹³² Alliot R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

¹³³ Eastaugh A, Barnett M, Parlby S, Paxton P, Sackin P. Co-tutoring: peer-supported learning. *Education for General Practice* 1998;9:517-519

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distress and discomfort which can cause difficulties for themselves and others. The facilitators need to be able to recognize what is going on for all participants, including themselves and be able to handle it constructively. For this reason we believe that the facilitators should have had experience and training in counselling skills and be committed to maintaining a high degree of self knowledge.

These requirements are distinct from being a doctor, even a doctor with experience in medical education, but can be found also in people with specific training in life-skills education or counselling facilitation. The facilitation team is stronger for reflecting the diversity of the participants. This can be particularly important in groups where the gender or culture divide unequal and participants are liable to feel isolated about such issues.

258. **Bregazzi and colleagues¹³⁴ reporting on the experience of GPs in a Career Start scheme comment**

Experience in County Durham suggests that successful mentoring in this context depends on having a clear and limited purpose, time, adequate training, and the formation of a relationship that is uncomplicated by power dynamics or role conflict. Colleagues need options to choose their mentors, a negotiable process and a mechanism to review the relationship.

and

GP tutors are well placed to act as mentors for newly qualified GPs.

259. **Further they conclude**

In common with the other schemes, mentoring was incorporated into GP Career Start as a means of supporting induction, personal and professional development. Yet evaluation has shown that there was a lack of coherent practice to justify the term. The mentors, who were aware of being ill- equipped for the role, received little or no instruction in mentoring. Some of the learners were disappointed to the point of changing their mentor during the year. Even so, initial scepticism about the value of mentoring was replaced for many by a desire for effective mentoring. This desire has been addressed by the scheme and training for mentors has been introduced.

260. **Black¹³⁵ reports that, as medical director, he set up the mentoring scheme in the trust as part of new consultant induction. This encompasses meeting the medical director, meetings with relevant colleagues, a job plan review at six to eight weeks and first appraisal, and an 18 month, compulsory ten-day continuing professional development programme which is organised on a rolling basis.**

261. **Mentors (who only later in the programme had any preparation for the role) were chosen from senior consultants without a major management role. The matters to be discussed were left to the mentor and new consultant to decide. The author concludes from his experience as the scheme organiser**

Ideally, there should have been training for all mentors before the programme started and there is little doubt that there should be more opportunities for mentors and mentees to choose their own partners. Mentoring may also work better if it is with someone in the same specialty. However, this programme was deliberately set up not to be in the same specialty, as it was thought likely that many of the problems would be colleague related in their new departments and the most important opportunity would be to discuss this confidentially with

¹³⁴ Bregazzi R, Harrison J, van Zwanenberg T. Mentoring new GPs: experiences from GP Career Start in County Durham. *Education for General Practice* 2000;11:58-64

¹³⁵ Black D. Induction for newly appointed consultants. *Clinician in management* 2002;11;9-13

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someone outside the department. However, the feedback, both of the specific programme and of the survey (see later), suggested that enough people gain from this to continue to offer the programme to all consultants when they start.

262. Connor and colleagues¹³⁶ used a questionnaire survey to assess the impact of their regional mentor development programme on participants' abilities to set up mentoring networks in their own places of work. They conclude

Newly trained mentors may feel out of their depth and there was evidence that some had felt this way, but all gave examples of how they had managed this, including taking time to reflect upon the situation and getting help through the network. Ethical and professional issues encountered included: issues about other colleagues; sexual harassment in the department; confidentiality, and concerns about the professional competence of the mentee. The mentors identified their most important contributions and these included: listening and being a sounding board; offering support; valuing and availability; being a role model; facilitating insight and change; offering confidentiality and a safe place to talk, and achieving retention in medicine.

Factors affecting the implementation of mentoring networks had been identified by the programme organizers and by the focus groups. Thus, 18 items were included on the questionnaire. Six of the 18 items are about the place of mentoring within the NHS organization (Table 5). These results identify the importance of placing mentoring within the appropriate cultural context. Mentors need time to mentor and they recognise that support will be necessary from both managers and senior medical staff. The other 12 items focus upon factors affecting the interface between mentor and mentee. In Table 6, the importance of trust, confidentiality, realism about the limitations of the mentor, feeling confident and setting clear boundaries are all identified as very important. These results are similar to findings from other mentoring schemes. Although the original intention of mentoring training was to develop skills to use with junior doctors, it became apparent that the senior doctors were gaining much from using these skills in co-mentoring, both formally and informally.

US literature

263. Barr and colleagues¹³⁷ suggest that departments should generate 'paper mentors' which deal with matters such as departmental expectations, lists of local experts, grant and manuscript writing, risk management, contract negotiation and public relations.
264. Souba¹³⁸ states that mentoring is a core competence of any outstanding department of surgery. The author suggests that building superior mentoring skills begins with an understanding of what mentoring is and recognising its value to the department. Leaders in the department must also emphasise the growth and development of the young people as well as building the department. He suggests that mentoring goes beyond obligatory relationships and is based on trust, commitment and unselfishness. Although the author suggests that fundamentally it is 'an affair of the heart, not the head' he also states that it encompasses a set of skills that can be

¹³⁶ Connor MP, Bynoe AG, Redfern N, Pokora J, Clarke J. Developing senior doctors as mentors: a form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors. *Med Educ* 2000;34:747-753

¹³⁷ Barr LL, Shaffer K, Valley K, Hillman BN. Mentoring. Applications for the practice of radiology. *Investigative Radiology* 1993;28:71-75

¹³⁸ Souba WW. Mentoring young academic surgeons, our most precious asset. *J Surg Res* 1999;82:113-120

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developed and enhanced. He suggests that experience is the single best way of learning to mentor, through test runs, trial and error, and examining their mistakes, people develop their mentoring abilities. Therefore, junior faculty should be given every opportunity to practice their mentoring skills and these should be evaluated. Formal seminars, workshops and programs can help and solidify essential mentoring behaviours. The author gives a checklist of action for senior and junior faculty in this regard. The author emphasises that mentors are people who are in the business of maximising personal potential. They help us appreciate the value of sharing the potential they help to cultivate in us with others around us; they inspire us to want to give back – not out of guilt or debt, but out of gratitude, decency and humility.

When the residents reflect on the special relationships that they were a part of during their training, they invariably feel fortunate and indebted – sometimes they are moved and humbled. When this happens, they genuinely want to give back. They, too, want to become great mentors. When they do, new leaders emerge, and the scales that measure excellence are tilted in favour of the kind of academic surgery department of which we all want to be a part.

265. In a later paper, the same author¹³⁹ looks at the relationship between informal, spontaneous mentoring and formal arrangements for bringing relationships into being. He puts forward the argument that allowing mentoring to occur spontaneously assumes that it develops naturally without any formal effort and also can result in mentoring not being a high enough priority at the departmental level. He suggests that, when a departmental commitment to mentoring is not a priority or when a clear sense of what effective mentoring really entails is lacking, competent mentors may fail to develop. He further suggests that

many departments have become so consumed with dealing with the pressures and demands of a rapidly changing health care environment that there is little, if any, time for activities like mentoring

266. Jackson and colleagues¹⁴⁰ suggest that at institutional level mentoring should be formalised and recognised as a professional activity like any other and that academic institutions should increase the likelihood of successful mentoring relationships by bringing junior faculty members and potential mentors together in a systematic way early in the careers of new faculty members. They suggest that potential mentors and mentees should meet in social as well as professional settings to begin the networking process. They suggest there are several ways to facilitate these relationships without making assignments. The authors remark that mentoring relationships will evolve as both parties learn about one another but the outcome is uncertain. It is critical that the relationship should be regarded as ‘no fault’ and that either party has the option to terminate for good reason without risk or harm to careers. The authors suggest that formal visible systems for mentoring make the connections easier for the potential mentors and mentees and institutions can encourage and reward mentors by publicly recognising their efforts as well as by scheduling formal time to the activity.

¹³⁹ Souba WW. The essence of mentoring in academic surgery. *J Surg Oncol* 2000;75:75 – 79

¹⁴⁰ Jackson VA, Palepu S, Szalacha L, Caswell C, Carr PL, Inui T. ‘Having the right chemistry’: a qualitative study of mentoring in academic medicine. *Acad Med* 2003;78:328-334

267. Assigned mentoring can be useful, but the environment must support the mentee in finding another mentor if the current one is not meeting his or her needs. Institutions should make women and minority mentors available to faculty members, but not assume that all mentees would prefer a mentor who is of the same gender or race.
268. Souba¹⁴¹ suggests that it is difficult to measure the benefits of effective mentoring and points out that the payback often takes many years. In the next part of the paper, he puts forward a number of constructs suggesting how mentoring should be regarded as a core capability. Investment into training a clinical surgeon or surgical scientist is substantial and must be viewed as a strategic investment. He puts forward a formula:

return on mentoring (ROM) = mentee growth and development ÷ mentor effort invested.

269. He further suggests that growth and development of the mentee is the critical endpoint by which mentoring effectiveness is measured. He also further suggests that

a comprehensive mentoring strategy will help create a culture that is able to respond swiftly to a rapidly changing and tumultuous external environment.

270. Souba puts forward a view that where a department is doing well but mentoring investment is low it will only prosper in the short term.

On the other hand, a department that is performing only marginally, but in which there is strong mentoring, can use that capability to align people with a shared vision and make the necessary changes to produce significant results.

and

More change demands better mentoring and more of it from more people to ensure that the core ideology of academic surgery is preserved. In this light, mentoring is an essential component of the glue that binds the faculty and residents together.

and

What makes the difference is (their) willingness to always act in the best interests of their mentees and to genuinely want their mentees to do better than they have done.

271. In their account of the development of a mentoring program in a department of academic radiology, Illes and colleagues¹⁴² state

Coexistent with the emerging need for formal mentoring was the establishment of an infrastructure in the department dedicated to research development. This effort was designed to assist all faculty in developing a trajectory for extramural funding and benchmarks for success, and provided substantial mentoring in this area. Nevertheless, as funding is only one dimension of activity for faculty in the department, the need for a comprehensive approach to faculty development was clearly mandated. To this end, our program was designed to operate in real time for the presumed benefit of all faculty in the department and, therefore, was never set up as an experiment.

272. They advise the following

¹⁴¹ Souba WW. The essence of mentoring in academic surgery. *J Surg Oncol* 2000;75:75-79

¹⁴² Illes J, Gover GH, Wexler L, Leong ANC, Glazer GM. A model for faculty mentoring in academic radiology. *Acad Radiol* 2000;7:717-724

- A mentoring program must be customized to meet the specific needs of the faculty and requires multiple phases of development that span conceptualization, testing, and evaluation before refinement and final implementation.
 - Programs must be established cooperatively and efficiently so that participation is a mutually rewarding opportunity for both mentors and junior faculty, rather than an obligation.
 - The mentoring relationship must take into consideration the whole person and every aspect of the career being mentored.
 - Mentors need to be prepared with information on promotions and terms for career advancement.
 - The mentoring relationship should not preclude junior faculty access to all faculty
 - The mentor-junior faculty relationship is multidimensional involving research, clinical, and teaching components. With the increasing pressures imposed by the rapidly changing health care system, the academic "triple threat" requirement facing radiology faculty today becomes ever more difficult to achieve and evolves as an essential and dominant focus of the mentoring process.
273. Wright and colleagues¹⁴³ writing from the perspective of a medical group practice state that the following conditions must exist: (1) frequent and open interactions between mentor and protégé, (2) the mentor must be honest, open and supportive and (3) the organisational culture, values and norms must encourage the openness.
274. These authors identify some obstacles and risks which militate against successful mentoring which include the reward system which gives low priority to human resource development, lack of interaction and relationship building opportunities, a culture which makes mentoring and other relationships seem hypocritical, relationships that grow beyond the original intention, organisational members' assumptions, attitudes and skills that interfere with developing relationships. The authors suggest that damage can be done if a mentor does not possess the essential human characteristics that promote nurturing, caring, and the ability to listen. Further harm may accrue if the mentor is effective early on but then falls from grace as a result of their actions. The authors suggest that because the mentoring relationship is full of traps
- many organisations shy away from involvement and maintain a strictly business-like relationship with a new entrant.
275. The need for personal interactions is a main finding from the 2002 paper by Ramanan and colleagues¹⁴⁴ from Harvard Medical School. The authors sent out a postal questionnaire to fulltime house officers, fellows, instructors and assistant professors (n=8,397). Only the results from instructors and assistant professors are given because of a low response from the other groups. The authors state
- ...seven specific qualities of mentoring were significantly associated with increased overall satisfaction with mentoring, after adjusting for sex, ethnicity, and academic rank. In the domain of personal communication, keeping in touch

¹⁴³ Wright WR Jr, Dirsra AE, Martin SS. Physician mentoring: a process to maximise the success of new physicians and enhance synchronization of the group. *J Med Pract Manage* 2002;18:133-137

¹⁴⁴ Ramanan AR, Phillips RS, Davis RB, Silen W, Reede JY. Mentoring in medicine: keys to satisfaction. *American Journal of Medicine*. 2002;112:336-341

regarding progress and not abusing power were significantly associated with satisfaction with mentoring. In the domain of professional development, providing counsel on professional decisions and providing help with building professional networks were associated with satisfaction. In the domains of skills, research, and academic guidance, providing advice relative to career plans and research and providing opportunities to develop communication skills were significantly associated with satisfaction with mentoring.

276. **The authors conclude**

Mentoring programs may be more likely to be successful and effective if they are based on the specific characteristics of successful mentoring identified in this study, with an emphasis on providing advice and building the mentor-mentee relationship. Asking mentors to keep in close touch regarding their mentee's progress and to provide thoughtful advice on career plans may seem intuitive to mentors, but formal instruction on mentorship is likely to increase the frequency and effectiveness of these activities. Similarly, by teaching mentors the importance of helping their mentees plan for the future by building professional networks and providing counsel on professional decisions, mentorship development programs are likely to yield more satisfying relationships for junior faculty.

277. **Moats Kennedy¹⁴⁵, who is Managing Partner, Careers Strategies, Wilmett, Illinois warns about the dangers of promising mentoring programs to job applicants if they never materialise.**

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. If you are considering a mentoring program or becoming a mentor yourself, here are some points to ponder: (1) if you can't (or won't do it) give convincing reasons up front, (2) establish the rules of engagement, (3) a mentoring relationship doesn't guarantee loyalty (4) having a protégé has political risks, (5) you can't force anyone to take advice and (6) expect a quid pro quo.'

278. **The author suggests that if you have been assigned to be a mentor, you must do so – or decline very gracefully immediately. If you are the one assigning people to mentor and they balk, let them off the hook. One of the most mentioned reasons given by new hires for moving on within a year was the lack of a mentor. The author warns strongly against becoming a mentor if the inclination and time needed are not available. The author states that unsatisfied expectations will sabotage mentoring relationships. It is important to explore upfront what the protégé wants from the relationship and respond honestly. This will enable you to gauge the time commitment and your own willingness. Weekly meetings are probably too frequent; once every six months is probably too infrequent. Under the heading 'the mentoring relationship doesn't guarantee loyalty' the author states that although time and effort may be put into a protégé they may well leave. Workplace relationships, however invested both parties are, are not expected to be happily-ever-after ones. Suggesting that having a protégé has political risks the author states that protégés will interact with most peers and, therefore, the mentor needs to be discreet, bearing in mind the axiom 'two people can keep a secret if one of them is dead'. The temptation to pass on hot new gossip may overwhelm even the best judgement.**

¹⁴⁵ Moats Kennedy, M. Someone promised mentors: will you deliver? *Physician Exec.* 2001;27:77-80

Under the heading ‘You can’t force anyone to take advice’ the author suggests that if a protégé appears to balk at every suggestion, try letting her mentor you. This may provide a major growth opportunity for you.

The greatest danger in rising to the top is having no one who will question your ideas or force you to defend them as you had to when you were a neophyte.

279. Mentors can expect a protégé to reciprocate in areas in which they are more expert - ‘paybacks reduce guilt.’ The next section is headed ‘Mentoring is for any new employee and not just for young workers.’ The author suggests that peer mentoring for any new employee can be very effective as the peer can answer questions better than a boss who ‘wears the organisation like an old shoe.’
280. Finally the author suggests that
- some frank discussions with HR are in order. What are recruiters promising? Recruiting resembles sorority/fraternity rush more closely than any other activity. Everyone promises what they believe will sell the other side and the manager who ends up with the pledges may be endlessly and unpleasantly surprised by what he or she is expected to do.
281. Rodenhauer and colleagues¹⁴⁶ mention barriers to mentoring described by Murray (Murray M. *Beyond the myths and magic of mentoring: What mentoring is – what it is not*. San Francisco, CA: Jossey-Bass, 1991) that include
- pressure to take on the role, lack of requisite skills, not taking the role seriously, insufficient time to commit to working with protégés, lack of perceived benefits, possessiveness of protégés, curtailment of protégés’ needs to take the risks necessary for learning and resentment of protégés.
282. They quote Barr and colleagues (see ref in this document) who point out that ‘relative newcomers or lower ranking academicians might not perceive themselves as mentors.’ Gender and race issues (dealt with at length in one section of this paper) are mentioned as barriers to effective mentoring, as well as mentors tending to choose protégés who remind them of themselves. Other potential problems the authors lists include mismatches in terms of personality or interest or goals, multiple protégés (and favouritism), availability of suitable mentors, age factors, and sexual attraction.
283. Direct mention of ethical considerations does not seem to feature very prominently in papers about mentoring. However, in a 2001 paper, Tucker and Adams-Price¹⁴⁷ from Piedmont Geriatric Hospital, Burkeville, Virginia, and the Department of Psychology, Mississippi State University, examine professional codes of ethics as they apply to the mentoring of gerontology students, supervisees, or protégés. Ethics codes from member organisations Gerontological Society of America were analysed according to the specificity of their ethical mentoring guidelines. Three levels of specificity were identified. General ‘do no harm’ statements were most common. Clear, explicit guidelines or rules were much less frequent. Where explicit mentoring guidelines exist, they focus on the use or the misuse of the power of the professional/mentor in the mentoring relationship. The authors suggest that a

¹⁴⁶ Rodenhauer P, Rudishill JR, Dvorak R. Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry* 2000;24:14-27

¹⁴⁷ Tucker RC, Adams-Price CE. Ethics in the mentoring of gerontologists: right and responsibilities. *Educ Gerontol* 2001;27:185-197

professional requires a commitment to ethical principles and define ethical professional behaviour as ‘the translation into action of reflections of agreed-on sets of values shared by members of the profession’. They comment that gerontologists do not represent a single profession as they come from many disciplines with various codes of ethics that differ in many ways.

284. In the three levels of specificity detected in the various codes, the first level was a general ‘do no harm’ level such as ‘be honest, maintain integrity, be objective, be dignified, maintain objectivity’, etc. The second level required general standards for ethical professional/mentor – student/supervisee – protégé relationships. For example, ‘do not misuse influence and authority for students’. The third level was characterised by very specific standards such as ‘evaluate students fairly by clearly stated criteria explained beforehand,’ and ‘students are not to be coerced or deceived into research activities, including participation as subjects or investigators.’
285. The authors suggest that these specific rules can be divided into two categories: (a) appropriate use of the power of the professional/mentor, such as assisting in job placement and (b) abuse of the relatively unequal power relationship between the professional/mentor and the student/supervisee/protégé.
286. The authors comment on the restrictive nature of some ethical guidelines suggesting that they can do more harm than good. For example, guidelines that prohibit involvement outside the formal relationship can be counter-productive and result in both failure to celebrate success and abuse of the protégé (such as when post-doctoral fellows are discouraged from communicating with each other about their work which defeats the notion of a community of scholars working together in a collegial manner). They suggest that restrictions on ‘dual relationships’ is in part due to longstanding concerns of psychiatrists, etc. about the problems associated with dual relationships between therapists and patients. This kind of rigidity may prevent the development of the mentor-protégé relationship from being more collegial with time. Another reason for the concern about dual relationships is the potential source of conflict between mentor and protégé but the authors suggest that there is no evidence to suggest that this is more common when students interact outside the formal sessions. The authors also suggest that there is nothing wrong in mentors paying protégés to carry out tasks where there is no coercion or undue power exercised. The authors then look at protégé power suggesting that protégés can significantly affect a mentor’s reputation both positively and negatively.
287. The authors suggest that mentors have an ethical responsibility to ensure that protégés have proper exposure and experiences during training. They note also that some organisations
- have made it explicit that students, supervisees, or trainees are accountable to their professional mentor or supervisor for conforming their behaviour to that of the profession, whether or not they have a student membership in the respective professional organisation. From an ethics perspective, the student, supervisee or protégé’s behaviour is to be judged by the same code as full-fledged members of the professional organisation.
288. A mentor therefore not only has the responsibility to ensure that protégés behave ethically, but is also responsible to protégés for ethics education and modelling of ethical behaviour (citing Kitchener KS. Psychologist as teacher and mentor:

Affirming ethical values throughout the curriculum. *Professional Psychology: Research and Practice* 1992;23:190-195).

289. The next section of the paper deals with rights and responsibilities of mentors and protégés suggesting that the mentor should motivate the protégé to succeed in the area of study chosen and the protégé has the responsibility to understand that the evaluations are a function of the work rather than of the friendship. The mentor should also accept the protégé as an individual with a separate, unique intelligence and personality and the protégé should select projects that fit his or her interests. The mentor needs to give the protégé appropriate credit for the work done and the mentor needs to make sure that proposed projects are do-able. The protégé has a right to expect rigorous exposure to and experience with tasks, duties, responsibilities and competencies that will be needed in later professional roles. Further, there is an expectation that the mentor will assist the protégé in learning to make statements reflecting their professional expertise and the mentor will allow the protégé to increasingly become the lead person in statements or presentations. Finally, the mentor needs to help expose the protégé to the way that gerontology is practiced in the world outside of academia.
290. The authors, in conclusion, make the following points: ethical mentoring involves both the mentor and the protégé recognising their impact on each other; both must have a mutual understanding of the nature of the relationship; understand the limits and boundaries of the relationship and recognise when the boundaries have been crossed or become blurred; they must be continually accountable for not violating the trust between them.
- Both the mentor and protégé are likely to be more professionally competent, creative, and productive through the synergism of a good mentoring relationship.
291. The authors suggest that if protégés have good mentoring experiences then they will assume the mantle of mentor for new protégés.
292. In their 2001 paper, Cain and colleagues¹⁴⁸ review the findings of two large surveys of obstetric and gynecology fellows and residents taking the training examination. A complex picture of perceptions was found in which women residents – especially minorities – felt that men were mentored and recruited more for faculty positions, while men felt that women were mentored and recruited more. Fellows' reports of recruitment did not differ by gender. Most white residents did not perceive racial or ethnic bias in mentoring or recruiting while most non-white residents did. Almost a third of non-white women residents felt that supervisors were more likely to condescend to women and minority individuals.
293. The authors conclude
- All faculty need to carefully examine their behaviours and make the necessary changes to provide unbiased, effective support, and to encourage a full range of career options for all our young trainees.
294. Making having a mentor compulsory may not produce the desired result. The American Board of Obstetricians and Gynecologists requires every fellow to submit the name of their mentor and their current research project. However in a 2001

¹⁴⁸ Cain, J.M. Schulkin, J. Parisi, V. Power, M.L. Holzman, G.P. and Williams S. Effects of perceptions and mentorship on pursuing a career in academic medicine in obstetrics and gynecology. *Acad Med.* 2001;76:628-634

paper, Scribner and colleagues¹⁴⁹ report that a 1998 survey of gynecologic oncology fellows showed that 32 per cent did not have a mentor.

295. Although papers have shown that institutional position is important in effectiveness as a mentor, this is probably not sufficient on its own. In a paper setting out the results of a retrospective survey of pediatric surgeons, Thakur and colleagues¹⁵⁰ conclude that

Based on the results of our study, a mentor's influence on his trainee is not a by product of the mentor's own happiness or success in his field, but how he sets an example in clinical care, his suggestions and his own interests.

296. They also suggest that long term availability of the mentor is important.

Respondents identified mentor guidance as important for personal development, career choice, research development and clinical skills. Respondents felt that, after their research period, their mentor was important in influencing their specialty choice, providing help during the fellowship or job application process, serving as a model to emulate for patient care, and remaining as a friend after the training period.

297. The importance of there being enough faculty members to provide mentoring programs is referred to in a statement by the Committee on Pediatric Research¹⁵¹ about the need for education and training in child health research, the need for continuing education and access to research advisors to be available to practitioners and academic faculty. The statement recommends

to support mentorship, federal training grants should provide faculty salary support in addition to trainee stipends. Institutions applying for fellowship training support should describe their plans for mentorship activities. Federal agencies can develop means to offer, and perhaps even require, formal training for proposed research mentors as part of their agreement for funding fellowship programs (ref. Center for the Advancement of Health. *Cultivating capacity: advancing NIH research training in the health-related behavioural and social sciences*. Washington, D.C.: Center for the Advancement of Health; 1999)

298. In a study of public health students¹⁵² that matched public health professionals with graduate level students (n = 104), matches were prioritised by (1) field of experience, (2) geographical location, (3) public health setting, (4) race – ethnicity, (5) gender and (6) other stated preferences. There were certain guidelines for the programme but it was left up to the mentor – student pairs to determine the appropriate frequency and mode of communication. Material included a description of the benefits of mentor – student relationships and an outline of the top 10 tips for maintaining an effective mentoring relationship (no reference). An evaluation was done at nine months and a 60 per cent response rate obtained.

Results showed that e-mail was the most frequent mode of communication (52%) and that close to half of the participants connected more than once a

¹⁴⁹ Scribner, D.R. Baldwin, J. and Gold, M.A. Factors affecting fellowship satisfaction among gynecologic oncology fellows. *Gynecologic Oncology*. 2001;80:74-78

¹⁵⁰ Thakur, A, Sedorka, P. Cohen, C. Buchmiller-Kreyer, T.L. Atkinson, J.D. and Fonkelsrud, E.W. Impact of mentor guidance in surgical career selection. *J.Ped.Surg*. 2001;26;12:1802-1804

¹⁵¹ American Academy of Pediatrics. Committee on Pediatric Research. Promoting education, mentorship and support of pediatric research. *Pediatrics* 2001;107(6);1447-1450.

¹⁵² Mahayosnand PP. Stigler MH. The need for mentoring in public health. *Am J Public Health* 1999;89:1262-1263

month (51%). 39% of participants reported they had strengthened their interest in their chosen career field, 24% had developed new skills and 36% believed that their personal growth was facilitated. All respondents stated that they would like to be a mentor in the future.

299. **The authors conclude**

this suggests that successful mentor – student relationships may promote future mentoring.

300. The use of e-mail as a means of mentor and mentee keeping in touch was advocated in a follow-up letter¹⁵³. The author suggests that e-mentoring can enhance the programme by (1) participants can complete a web based application on which they can state their matching criteria, (2) matches can be made in a central, national data base, (3) important mentoring literature can be posted on a single web site, (4) interventions can be posted on the web to allow more time for individual consultation, (5) more time is available to design local and national participants' social events and (6) the programme can ultimately match pairs year round.

¹⁵³ Mahayosnand PP. Public health e-mentoring: an investment for the next millennium. *Am J Public Health* 2000;90:1317-1318

9. How do authors see the future for mentoring and how its development might be helped?

UK literature

301. Alliot's 1996¹⁵⁴ paper suggests that there is a need for standards to be set and a supervisory base to cover appointments, training and continued supervision. He further suggests that information gleaned by mentors from their mentees could reflect current feelings on morale, complaints and night visiting. It suggests that this information could be fed to local medical committees or the General Medical Services Committee but he emphasises that there are problems of confidentiality, mentored bias and appearing to be an agent of government.
302. Freeman¹⁵⁵ has challenged the release of information obtained through mentoring stating that confidentiality is of the essence. She raises¹⁵⁶ a number of questions for further consideration including
- what (if any) should be the relationship between mentoring and re-certification?
 - Do gender, culture and the organisational context of mentoring influence outcomes?
 - Is mentoring a device that simply preserves the organisational status quo, a temporary field dressing when more radical surgery is required?
303. Okereke and Naim¹⁵⁷ in 2000 state
- We feel that middle grade doctors especially in the A&E department are in a unique position. They already, by virtue of the working conditions, find themselves in regular close contact with the senior house officers. They are thus able to offer practical advice, emotional support and feed back where necessary. Offering middle grade doctors the time and resources necessary to serve as mentors will also provide philosophical support and a sense of fulfilment. Finally, a qualitative method of research in this area involving interviews with mentees, observation of the mentoring process and focus groups could all be used to explore this issue further. A long term study looking at the effects of mentoring on young medical graduates through their training period would certainly be welcome.
304. Connor and colleagues¹⁵⁸ make some recommendations for the future in their 2000 paper, as follows
- *Developing the mentors*
 - Regional support network
 - Facilitated debriefing sessions for active mentors
 - Development of a code of ethics and practice for mentoring

¹⁵⁴ Alliot R. Facilitatory mentoring in general practice. *BMJ* 1996;313:S2-3

¹⁵⁵ Freeman R. Information shared in mentoring must remain confidential. 1997. *BMJ*. (letter) 314:149

¹⁵⁶ Freeman R. Towards effective mentoring in general practice. *Br J Gen Pract* 1997;47:457-460

¹⁵⁷ Okereke CD, Naim M. Mentoring senior house officers. Is there a role for middle grade doctors? *Emergency Medical Journal*, 2001;18:259-62

¹⁵⁸ Connor MP, Bynoe AG, Redfern N, Pokora J, Clarke J. Developing senior doctors as mentors: a form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors. *Med Educ* 2000;34:747-753

- Annual regional or national training programme
- *Who needs mentoring?*
All junior doctors
Newly appointed consultants
Those senior doctors who may feel isolated, or lack confidence
- *Mentoring and the organization*
Joint meetings to be arranged of chief executives, human resource directors, medical directors and senior doctors to discuss the resource implications for mentoring in the Trusts
- *Widening the network*
Regional database to be developed across specialties and localities
Funding for a personal career service
Links with other organisations, for example, the British Association of Medical Managers (BAMM).

305. They suggest some issues for further debate as follows

- In what ways are mentoring skills transferable to the everyday work of the doctor?
- Is it advisable to develop hierarchical mentoring systems (for example, a senior mentoring a junior doctor)?
- What is the feasibility of training medical students and junior doctors in mentoring skills which they could use to help each other in a co-mentoring situation?
- Should doctors develop mentoring networks amongst themselves, or should they be part of a total organizational response to mentoring in a Trust?
- Should mentoring networks cross the boundaries between primary and secondary care, acute and community services?
- Has there been too much emphasis upon the mentoring needs of junior doctors, and not enough attention given to the provision of mentoring for senior doctors?

306. In their 2002 paper, Roberts and colleagues¹⁵⁹ conclude

Although consultants form a small portion of the workforce, their morale and functioning have a major effect on health care. An adequate system of support will simultaneously be in the interest of practitioners, patients and their carers, and non-medical colleagues. If appraisal and mentoring of senior doctors is only arranged when there is a perception that the doctor's performance is unacceptable, then it will be met with resistance. An alternative view is that mentorship and other supportive structures are of value to all consultants irrespective of performance, and usefully coexist with formal evaluation.

Mentorship is based on a continued emphasis on 'the person' of the doctor, alongside the acquisition and maintenance of knowledge and skills. It is suggested that the provision of a mentoring relationship for new consultants is only one part of a succession of facilitating relationships, which will optimally start on the first day of medical school, and continuing through the 'seven ages of medical practice', mirroring the progression from undergraduate studies to active retirement.

¹⁵⁹ Roberts G, Moore B, Coles C. Mentoring for newly appointed consultant psychiatrists. *Psychiatric Bulletin*. 2002;26:106-109

Mentoring for doctors: a look at the literature. A working paper prepared for the Doctors' Forum by Jolyon Oxley

US literature

307. In his 1996 paper, Setness¹⁶⁰ questioned how mentoring, this personal and unmeasurable input, can fit into a world of managed care and measurable outcomes. The author questions whether mentoring can still be seen as an opportunity to improve care and physician satisfaction or whether associating yourself with a colleague's care of a sick patient has become a potential liability. He points to the fact that doctors who are part of a large group are, in effect, all employees and, by necessity, compete to some degree for position and pay. This is distinguished arrangements where physicians owned their own practices wanting their partners to excel. He describes these as all being disincentives to mentoring but feels that we should move beyond them.
308. Setness raises the question of whether we are teaching the value of mentoring to the physicians we are training. He suggests that mentoring can go in many directions and involve many players.
- Older physicians can learn from as readily as teach younger physicians. The nursing staff has much to teach us, as we have much to share with them. Even patients are part of the mentoring circle. We can advise them on wellness and how to keep their bodies as healthy as they are able, and they can teach us about their illness and how to help them in the most meaningful way.'
309. This author concludes
- what an opportunity mentoring gives us as we step into bottom-line-driven medical systems, to preserve ourselves as individuals and to see the effects of our singular contributions in our colleagues.
310. Barondess¹⁶¹ points to developments that have threatened the survival of mentoring relationships in medicine, including growth in faculty and staff size and expanding science base and progressive sub-specialisation, time pressures on faculty members, the expanding managerial duties of senior faculty and the continuous search for funding.
- Overall, a young person in medicine now has much more difficulty in forming a comprehensive mentoring relationship with one person, encompassing a balanced mixture of breadth and expertise.
311. This author suggests that, to expand mentoring relationships in medicine, the implicit process should be more carefully examined and made more explicit so that modifications can take place and they can be subsumed as elements in education and 'enculturation'. He also suggests this will be important to re-establish an education community and reaffirm professionalism in medicine (Citing Swazey JP, Anderson MS. Mentors, advisers and role models in graduate and professional education. Washington DC: Association of Academic Health Centers, 1996). The author suggests that two types of investigation would benefit mentoring – cross sectional and longitudinal studies to evaluate the nature and career effects of traditional and formal mentoring relationships and demonstration projects that assess short and long term effects of introducing structured and supported mentor roles in the health professions. He suggests that there should be work to clarify the

¹⁶⁰ Setness PA. Mentoring. Postgrad.Med. 1996;100:15-22

¹⁶¹ Barondess JA. On mentoring. J R Soc Med 1997;90:347-349

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expectations of the roles of mentor and protégé and the objectives of formal mentoring relationships. He further suggests that there should be additional research addressing the issue of gender.

312. Drotar and Avner¹⁶² in a 2003 paper from academic pediatrics forewarn of threats to mentoring, using them as a justification for ‘a concerted approach to developing mentoring resources and strategies’.

... there are a number of significant threats to successful mentoring in pediatric departments in the 21st century. The most formidable are work-related stresses of pediatric faculty, who are confronted by the competing demands of clinical practice and era of managed care; the teaching and training of students, residents and fellows; and managing successful careers. In the current economic climate, mentoring is at risk as a ‘non-reimbursable activity’ that is targeted for cut backs or elimination. Indeed, some would justify this Spartan approach on the basis of their own negative experiences. Since they succeeded without help or mentoring, why can’t others? They may even reason that talented, motivated trainees will be helped by personally overcoming obstacles to career development without assistance from their mentors.

313. The authors also refer to the current workforce crisis affecting pediatric physician-scientists and clinician-educators, specialised approaches for talented women trainees and continued advocacy for federal training and loan repayment programs.

¹⁶² Drotar D, and Avner ED. Critical choices in mentoring the next generation of academic pediatricians: nine circles of hell or salvation? *J.Pediatr.* 2003;142:1-2

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