Towards effective mentoring in general practice

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SUMMARY

In South Thames, a three-year feasibility study was designed to explore the potential contribution of mentors in furthering professional development and increasing a sense of well-being among general practitioners. The study led to the establishment of an ongoing mentor project as a South Thames (West) Regional initiative, funded by the Postgraduate Dean of General Practice. This paper outlines the project's structure and administration. The concept of the holistic mentor model, together with a strategy (the reflective cycle) for purposeful intervention, is also described. The findings from the evaluation of the study illustrate the response of doctors to their mentor training, their early experience of taking on the role of mentor, and their reporting of the experience of those being mentored (the mentees). The issues relevant to the future of mentoring are commented on, to inform and encourage further discussion.

Keywords: mentoring; evaluation; professional development.

Introduction

THE organizational context of this mentoring initiative is the negative impact of enforced change, the consequence of which can be summarized as increased accountability with decreased professional autonomy — contributing factors in the demoralization and increased stress in the profession.[1,2] A more positive consequence has been the challenge to the innate defensiveness of medicine, in which doctors struggle to maintain their own and their patients' expectations that he should be infallible and all-coping. While negative stressors unique to general practice are rightly being identified and debated, there is a growing movement, led by the Royal College of General Practitioners, towards revaluing the strengths and rewards of general practice.[3] This has resulted in a number of projects that seek to promote professional well-being, and has triggered a growing interest in mentoring, albeit tempered with uncertainty: what does the task entail, and what are the resource implications?

The project's structure and administration

An initial two months of concentrated activity was needed to establish structures to advertise, deliver, administer, and evaluate mentoring. Once in place, all structures were revised and amended by the mentor team in the light of their experience and feedback from mentees. This proved cost-effective, reducing the time required to administer the project in the longer term.

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. The relationship between mentor and mentee is voluntary and confidential but formal, with mentees being allocated to a mentor rather than paired informally. This made the appointment of a project coordinator (working for 10 hours a week) critical for, in addition to administration, the more crucial task of allocating mentors to mentees requires particular local knowledge and sensitivity.

While mentees determine the frequency of meetings, a minimum of three a year is required by the project in order to meet the criteria of mentoring as a continuing relationship. The minimum time requirement for a mentor is therefore three half-days each year. However, most mentors, keen to broaden their experience, work with two or more mentees. Current meetings average five a year: a total of about 20 hours.

Mentors are reimbursed a half-day locum fee plus travel costs. Both mentors and mentees are credited with postgraduate education allowance for their mentoring sessions. The project leader gives 18 hours a week to the project, which includes facilitating the two tiers of mentor training to provide continuous learning for mentors and the maximization of their own professional development. The project functions within the action-research framework[4,5] used in the initial feasibility study. Evaluation is integral to the project's structure, with data collected from both mentors and mentees. A forthcoming pilot study will use this mentoring model with hospital doctors, enabling comparisons to be drawn between primary and secondary care mentoring.

Currently, 25 mentors work with the 68 mentees enrolled. The mentees include established practitioners, young principals, and retainers. All mentors are established practitioners, with a mix of age and sex. As a general guide to resourcing, the annual budget for this size of project is between £28 000 and £30 000 and, so far, this has allowed unlimited mentor interviews of two hours' duration. Future budget constraints may demand curtailment both on the number of mentor sessions (to, say, five sessions a year), and on the number of mentees and mentors working within the scheme. These constraints mean that the model of mentoring used must respond promptly and accurately to the needs of the recipient.

Holistic mentoring

The role and function of a mentor in general practice have been described elsewhere,[6,7] and the model of mentoring practised in the project is a development of that earlier work. 'Holistic' implies an intervention that holds together all three classic components of mentoring: continuing education, personal support, and professional development. The mentor affords equal weighting between these elements, helping the mentee to acquire and integrate new learning (education), manage transitional states (personal support), and maximize his or her potential to become a fulfilled and achieving practitioner (professional development).

While models of mentoring are shaped by the settings in which they occur,[8] the three elements referred to are core characteristics of mentoring, distinguishing mentoring from other forms of professional support. The mentor's ability to move freely between the three components addresses a fundamental problem of professional development, namely that individuals can be blocked from maximizing learning opportunities by the preoccupations and competing demands of their professional lives. Acknowledging and understanding these preoccupations is an essential consideration if mentoring is to be effective in a profession in which stress and demoralization are known to be widespread.[9]

Within this model, a strategy was designed: the reflective cycle (a full description is contained in a forthcoming publication, *Reflecting on reflection — the art of reflection in the mentoring relationship*). It is drawn from educational concepts of

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learning cycles[11] and developmental psychology.[12] Using the cycle introduces a purposeful climate in which to establish a mentoring relationship, announcing mentoring as a professional activity, that goes beyond a peer conversation. Mentors use the cycle to facilitate reflection on experience in personal and professional life, identifying factors inhibiting development. From this shared reflection and understanding, realistic and manageable goals for future development are set. The mentor continues to support and review their implementation.

The reflective cycle was also intended to support the fragile process of the opening interview. Literature from other helping professions[13,14] documents the crucial nature of the first contact in the helping process. The cycle aids the sensitive management required from the mentor as both sides seek to establish confidence in each other, and set the tone for future meetings. At this point the mentor feels most vulnerable and least certain; conscious of being assessed, he or she is likely to succumb to the easier option of superficial conversation. The model seeks to balance structure, necessary for a purposeful, outcome-based mentor intervention, with flexibility, to encourage reflection on the present self (who I am now) and exploration of the future self (what I might become).

The mentors' experience of introductory training

Perceptions of mentoring

The introductory workshops, which prepared potential mentors for their role and introduced the holistic model, also gave insights into the emerging concept of mentoring in general practice. It emerged that, for many, the motivation to take on the mentoring role stemmed from their perceived loss of professional collegiality (a consequence of the growth of the business element in general practice), and their wish to support, rather than compete with, colleagues.

A comfortable view of mentors as facilitators was tempered with the less comfortable notion that they might also have to be 'all-wise and all-knowing'.[16] However, potential mentors seemed to know instinctively that mentoring was more than just conversing or befriending: 'There must be certain factors that make it work — we need to know what they are.'

Testing the holistic model — opportunities and threats in the reflective cycle

Potential mentors were keen to test out holistic mentoring for themselves, to gauge its impact and relevance in practice. Within the safety of the structured workshop, participants began by using the reflective cycle, pairing off to ask developmental questions in the area of their partner's choice before reversing roles. The doctor's familiarity with asking questions and taking control made it initially challenging for participants to receive a series of open-ended questions. Overcoming this, they expressed surprise at the energy released by sustained reflection, at how much material they found to talk about, at the ease with which it could be shared, and at the insights gained from sharing it. This exercise illustrated quite powerfully the potential outcomes of structured reflection on experience. Many participants were taken aback to discover that using a comparatively simple and manageable structure could 'take you further, faster', and were sensitive to the implications of travelling fast, particularly when their medical upbringing instilled in most doctors a sense of closed self-reliance.

Recognizing that working at this different level contained both opportunities and threats, potential mentors were rightly anxious. Mentoring was likened to Pandora's box, providing opportunities for creative exploration and change while threatening to release chaos and uncertainty; chaos would surely follow if mentors started to become what one doctor described as 'pseudo-therapists and fake counsellors'. Several participants were confident that, as doctors, they 'knew about psychotherapy and counselling', but the anticipation of dedicated time with their mentee led to the salutary realization that their knowledge was based only on extended consultations at the end of a surgery, whereas their mentor sessions would last over an hour. This introduced the theme of maintaining boundaries in the mentoring task, reinforcing the importance of working from a role definition that makes these boundaries clear, and having support structures in which mentors can monitor their practice.

The model in practice

The mentors' early experiences

All mentors said they felt vulnerable and 'on trial' when first meeting their mentee. Although well-versed in the art of interviewing patients, working with their peers was very different. This undoubtedly influenced their readiness to use the reflective cycle, which they felt would ensure a well-structured beginning to their mentoring relationship. The cycle served them well as a route map, which could be discarded once the relationship became established and gained its own sense of direction, but mentors reported that it did not alleviate their natural anxiety to 'get it right' for their peers. Although they keenly felt the responsibility of their task, they enjoyed the challenge of responding appropriately to the needs of the mentee, and acknowledged the enormous privilege of their position. How did this positive beginning correlate with the experiences of those on the receiving end of the mentors' intervention?

The mentees' early experiences

To avoid intrusion into the confidential relationship between mentor and mentee, ongoing data were collected using six monthly review sheets in a questionnaire format. Mentees completed an anonymous review form seeking responses to their experience of mentoring, and asking about:

- Their expectations of mentoring
- Any unexpected developments arising from the intervention
- The main themes of the mentoring sessions
- The identified outcomes.

Expectations of mentoring

The following summary draws on this data, together with interview material from the evaluation. Support, independent advice, and career guidance were common expectations. The most important factor was the independence and neutrality of the mentor, supporting the decision to allocate mentors on a neutral basis with mentor and mentee unknown to each other.

Asked if anything unexpected had come from mentor interviews, the ability to change was dominant. In their professional life, mentees realized their dormant strengths as agents of change. Rather than waiting with mounting frustration for others to act, they seized the initiative to progress the management of their practices. Similarly, in their personal life they re-examined their approaches to life situations. Alongside this was the 'feel good' factor that came from being listened to and supported.

Main themes in discussion

Career development was a major theme with mentees using their sessions both to plan their future and as routes to achieve it. More significantly, when seeking feedback from their mentor on

their clinical and organizational management, they stressed the lack of supportive feedback in their professional life. Constructive feedback is a pre-requisite of professional development,[17] particularly for young practitioners,[18] and this aspect of the mentoring relationship has clear implications for the process of recertification.[19] The neutral and confidential mentoring relationship allowed for more personal feedback. In sharing the distress arising from dysfunctional relationships with partners, mentees sought feedback on how they might handle their role with partners more effectively, to benefit the organization of their practice.

Regarding personal support, mentees most frequently sought help in managing boundaries between work and personal life, and devising coping strategies for the stress experienced both at home and at work. This theme reinforces earlier statements on the importance of boundaries. In practice, mentors found that making links between personal and professional life in their work with mentees proved helpful and effective. Equally, mentors consistently used their support groups to carefully patrol the boundaries, ensuring their excursions into personal life stayed within their mentor role. Occasionally, mentors referred their mentees elsewhere for counselling or stress management, but only when both saw this as appropriate.

Educationally, the main themes were clarifying educational goals and identifying educational futures. Additional advice was given on studying for the MRCGP exam and recognizing individual learning styles.

Outcomes of mentoring

When asked to identify early outcomes, the strongest theme was of achieving change through the medium of a reflective, supportive mentor relationship, resulting in changed perspectives and a re-ordering of priorities. The re-ordering most frequently cited was sacrificing income in order to improve the quality of life, and learning to care for oneself. Insights into their own behaviour brought attitudinal change and enabled previous confrontational approaches to difficult events to give way to more considered responses, which were described by mentees as being 'more mature', and which (somewhat to their surprise) achieved better outcomes. Practical outcomes, stemming from a raised awareness of the immediacy of professional development, were also cited: educational programmes and developmental plans had been drawn up and ideas put into action.

Does mentoring contribute to professional development and well being?

Initial data from this small qualitative study, confirmed by later findings as the project progressed, indicates that 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 frameworks 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.

Apparent in the continuing dialogue with all participants as the project develops is the empowering process of mentoring. The continuous, supportive nature of the mentoring relationship enables mentees to achieve a more robust professional identity,[20] empowering them to take control, rationalize pressures, and formulate and implement change in their working lives. This stronger position has positive implications for both the quality and the competence of patient care.

Secondary benefits accrue to the mentors. Their own professional development is enhanced, first through the challenging interaction with their mentee, and secondly from their pioneering role, acting as agents of change in their profession.[21] As a result, the project finds no difficulty in recruiting doctors to act as mentors.

Implications for the future

These benefits, when set against current concerns about recruitment and retention of expensively trained practitioners, would seem to outweigh the comparatively modest cost of maintaining a mentor scheme. However, a recent conference on mentoring in general practice[21] provided a forum for wider debate on questions that relate to the future of mentoring in the profession. The implication for long-term funding was only one question. Others included; what (if any) should be the relationship between mentoring and re-certification? Do gender, culture, and the organizational context of mentoring influence outcomes? Is mentoring a device that simply preserves the organizational status quo, a temporary field dressing when more radical surgery is required? 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.[22] A continuing debate on these and related issues will be a timely contribution in the life-cycle of mentoring in general practice.

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