Exploring mentoring

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BMA

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- Hepatitis C – FAQs (web only) (2003)
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- Health & ageing – web resource (2003)
- National health service induction programme for doctors (web only) (2003)
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Introduction

The BMA strongly advocates mentoring at all stages of medical education and throughout doctors' careers. This report stems from a 2003 ARM motion that asks the BMA to lobby for the development of a mentoring system for all doctors and calls on the government to resource this appropriately. The recommendations in this report provide some theoretical and practical support for this motion. Mentoring is a dynamic process. Doctors' needs change throughout their careers and mentoring can provide relevant and applicable guidance, ideas and advice.

At a time when resources within the medical profession are stretched, both in terms of time and finances, mentoring should be conceptualised within that framework. This report attempts to present mentoring within these limitations and boundaries. It reviews the increasing interest in mentoring on the medical education agenda and presents some insightful research generated through contact with postgraduate deaneries. This report most significantly highlights the need for the continued endorsement of mentoring in terms of resources, development and support. It offers recommendations with supporting evidence.

The BMA supports mentoring. In response to the government's *Modernising medical careers*, the BMA promotes mentoring as an essential component of career advice for both medical students and doctors. *Sign-posting medical careers for doctors* underlines that the current provision of career advice and guidance for doctors is not adequate.

The BMA acknowledges that targeting mentoring schemes towards specific groups can be effective. For example, mentoring can be of great assistance to refugee doctors.[1] The BMA's international committee provides guidance and advice for assisting refugee doctors. In addition, the BMA's medical students committee policy guide reiterates the importance of mentoring for medical students. It emphasises that mentoring should be available to all medical students for confidential professional and personal advice. The BMA has recently launched a Doctors for Doctors unit. Its remit includes responsibility for helping doctors make informed decisions about their health; facilitating access to appropriate care and supporting doctors through this process. (Contact: info.d4d@bma.org.uk)

The BMA is working closely with the Department of Health's Improving Working Lives (IWL) initiative, which has produced an informative and

comprehensive series of documents related to mentoring.[2] The work is based on primary research and serves as a valuable resource for both doctors and health professionals. This resource aims to contribute to the notion that mentoring is an important component in the lifelong learning of a doctor.

Mentoring and the medical education agenda

Explaining mentoring

The term 'mentoring' features widely in the health promotion literature. One article categorises the literature according to the following four themes:[3]

1 studies which examine the application of mentoring
2 descriptive and practical accounts of mentoring
3 accounts of what mentoring should, or might, be about
4 step by step guides and manuals for developing a mentoring scheme.

These categories are helpful in providing some guidance and a method of understanding mentoring.

Mentoring has become increasingly prominent on the medical education agenda. Most medical schools, postgraduate deaneries, royal colleges, and NHS trusts mention mentoring in some context. It is purported to be important to these organisations. The Department of Health and the NHS also value mentoring, as part of the IWL[4] initiative. Despite the prevalence of mentoring schemes, it is often unclear how many doctors participate.

The current literature outlines some of the difficulties in defining mentoring. Explaining or defining mentoring is difficult and often confusing. There exists a wide spectrum of definitions and explanations. Mentoring can be referred to as counselling, a type of appraisal, advice, career guidance and/or discipline. The GMC uses a different definition of mentoring (a more thorough explanation is provided in appendix B). Additionally, the role of mentoring often changes throughout ones' career. The Standing Committee on Postgraduate Medical Education (SCOPME) established a definition that features widely within the literature.

Established definition of the mentoring process:
'The process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor, who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee.'[5]

Below are other definitions that appear throughout the literature. They are included here to demonstrate the existing scope and to provide a broader understanding of the mentoring spectrum.

Various definitions of mentoring:

Mentoring is a 'personal helping relationship between a mentor and mentee/protégé that includes professional development and growth and varying degrees of support.'[6]

Mentoring is:

- a professional relationship
- support for professional development
- personal support
- a partnership lasting over a fixed time scale
- a significant process during an individual's career.[7]

'A particular form of relationship designed to provide personal and professional support to an individual. The mentor is generally more experienced than the junior colleague and makes use of that experience in a facilitative way to support the development of the junior colleague. Mentoring is used to assist individuals at specific stages of development or transition and lasts for a sustained, but defined period of time. The mentoring relationship provides a developmental opportunity for both parties and can thus be of mutual benefit.'[7]

'A mentor is a senior and respected member of the medical profession with whom you can meet on a regular and continuing basis, and are able to discuss issues of career progression under the problems that may arise, bringing to bear their many years of experience of these sorts of issues. The mentor need not necessarily be someone in your own organisation, and I would think that sometimes there are advantages in their being someone who is not in a direct management role with yourself. The idea, I think, is to explore issues in a constructive and non-threatening way, but allow you as the mentee the ability to discuss things and make up your own mind rather than tell you what to do.'[8]

Other research has defined mentoring comparatively or based on what it is not. For example, Dancer[9] differentiates the roles of an expert and a mentor.

Differentiation of roles

Expert	*Mentor*
• has expert power	• shares power
• emphasis on content	• emphasis on process
• diagnostician	• facilitator / enabler
• gathers and analyses information	• enables information gathering
• outlines options	• manages process
• relationship is important	• relationship is key
• knows best / better.	• doesn't know best.

Source: Dancer J M (2003) *Mentoring in healthcare: theory in search of practice?* Clinician in Management.

These examples highlight that there exists a diverse range and scope of definitions and explanations related to mentoring. Likewise, there are various resources that provide information about current mentoring schemes available to doctors. In order to offer something new to the agenda, the BMA approached postgraduate deaneries to learn about the type of mentoring programmes and schemes that they offer.

Postgraduate deaneries' mentoring programmes

Postgraduate and GP deaneries were contacted by post to explore the range of programmes offered on a practical level. Deans were asked to consider:

- availability of mentoring schemes (including how doctors find out about mentoring, the aims of mentoring, target groups, take up rates)
- structure and framework of schemes
- plans to increase or decrease the current initiatives
- feedback that they may have received (both positive and negative)
- training provision for both mentors and mentees
- other comments that they may have about mentoring.

The responses varied widely from no formal mentoring programmes to comprehensive initiatives. The overall response rate was 56 per cent (14 responses).

Some deaneries informed us that mentoring was part of the remit assigned to trusts and therefore was not centrally coordinated (for example, Eastern Deanery and South Western Deanery). There are also many ad hoc mentoring projects referred to (for example, North of Scotland, Oxford). From the responses offered, mentoring schemes coordinated by the deaneries were often targeted at consultants (for example, Scotland, West Midlands, Wessex and Oxford) and GPs (for

example, West Midlands, Wales, Inverness, Oxford and West of Scotland). Other schemes specified were focused towards overseas and international doctors (for example, Manchester); refugee and asylum seeking doctors (for example, West of Scotland). Others defined themselves by their process such as a peer mentoring scheme and a counselling service.

The deaneries are valuable resources for doctors and have varied interests in mentoring. Some deaneries advised that they are able to refer doctors to relevant schemes, whereas others coordinate the schemes themselves.

Recommendations

The broad scope of mentoring translates into a need for the BMA to continue to lobby for the continued support and resourcing of mentoring initiatives. Although there seems to be an increase in the availability of mentoring schemes, implementation and monitoring of those schemes do not necessarily reflect the increase. The BMA recommends the following actions to support the ARM motion.

1 Access to mentoring should be encouraged at all levels throughout ones' medical career.

2 Mentoring should be encouraged through structured and flexible frameworks.

Mentoring is identified as beneficial and advantageous. There is increasing evidence of the positive effect of mentoring in medicine.[10] The benefits are difficult to quantify. They also vary for individuals and organisations.

Some of the benefits most often associated with mentoring are that it can:

- improve work performance
- offer scope for new ideas
- enhance the mentee's relationship with the company and improve retention rates
- help develop better communication throughout an organisation
- reflect an organisation's commitment to training and development
- positively change the interface between managers (or employers) and employees.

Source: Incomes Data Services (2000) *Personnel policy and practice: Mentoring. Study 686.* Surrey: Unwin Brothers, The Gresham Press.

Some benefits reported by doctors include:

- regained confidence and job satisfaction
- improved working relationships
- enhanced problem solving
- increased sense of collegiality
- making career choices.

Source: Oxley J & Fleming B (2004) *Mentoring for doctors: Sign-posts to current practice for career grade doctors.*

Arguably mentoring can also be utilised to 'support and promote cultural diversity'[11] in an organisation. For example, one scheme outlines its intention to help women consultants provide mentoring services for junior doctors and especially female doctors.[10] This is an

example of how mentoring can be used as a positive tool to enhance equality.

A mentoring relationship does not necessarily need to be confined to doctors. Mentoring can be enhanced through a perspective from outside medicine. For example, medical managers or people from outside the health sector with similar levels of responsibility could be potentially beneficial in a mentoring relationship.

3 Mentoring should remain voluntary.

The BMA strongly believes that mentoring should remain voluntary for both mentor and mentee. The voluntary nature of mentoring is a constant point of discussion within the literature. Debates are often centred on target groups and those who may benefit from mentoring.

There is some evidence to suggest that mentoring can be a method used to address issues of discrimination. For example, mentors from the same minority ethnic background can act as role models, which can positively impact the organisation more widely.[12] However, by making mentoring compulsory, especially for targeted groups, there is the potential for adverse effects.

There is a further linked debate about the degree of formality that a mentoring scheme should have. The complexity of this debate is that 'paradoxically, although it is the informality of these relationships that organisations value, mentoring schemes nonetheless require some ground rules to function effectively.'[12] Informal mentoring may be more fluid than a formal scheme. However, a formal scheme has a greater ability to ensure that those who wish to participate in a mentoring relationship will have the opportunity to do so. It is difficult to negotiate this tension, and the scale will vary. For example, hospital doctors in urban areas have different requirements to GPs in rural areas. In establishing a mentoring scheme it is beneficial to understand some of the complexities in order to best tailor the scheme to the participants and their circumstances.

4 The mentoring process should be continually supported by the relevant organisation.

Support needs to be continual in the facilitation of mentoring. Support is often offered at the inception of a scheme. However, problems do arise throughout the duration, for example, mentors and/or mentees wishing to be reassigned because one or both may

not feel as though they are benefiting from the relationship. Support mechanisms should be in place to accommodate these changes.

Furthermore, the legislative and organisational agenda are important influencing factors in mentoring. The public setting of the NHS and healthcare often places doctors and other healthcare professionals in a complex position. As public services are changing, arguably values and practices of the private sector are becoming more common.[3] This can translate into performance standards and targets being further integrated. Public services – especially healthcare provision – are also subject to intense regulation and debate by both the public and government, creating an additional layer of complexity.

Mentoring is offered as a component of professional development that can improve healthcare standards and services. With revalidation becoming linked to appraisals,[13] the role of mentoring may gain different meaning and more significance. It has been suggested that incorporating mentoring in the development of job plans for both the roles of mentor and mentee could be beneficial. Additionally, mentoring has become associated with CPD.[3] For example, some organisations award CPD points to mentors.

5 The potential advantages associated with mentoring need to be raised so doctors are more willing to participate.

6 A wider range of information should be offered to doctors in terms of the potential benefits and limitations of participating in a mentoring scheme.

Doctors have traditionally shown reluctance towards schemes such as mentoring. This could partly be the result of the institutional setting, time constrains and/or other pressures. In a comparison of doctors to other healthcare professionals, it is suggested that some doctors perceive 'mentoring as something rather "soft" and "girlie" '[14] implying weakness.

By raising awareness of the potential benefits of mentoring programmes through a flexible organisational framework, it is hoped that the perception of mentoring being only for those with problems will be negated. Mentoring should be promoted as a positive and active method to enhance ones' career.

7 Confidentiality should be respected and protected.

Confidentiality is a key component of mentoring. It has been argued that the success of mentoring 'depends on its confidential nature and the ability of the participants to speak freely, without fear of reprisal.'[15] If mentoring is a positive process (and not reactive or disciplinary) then confidentiality needs to be protected as a key feature of the process. In the evaluation of a mentoring scheme in the South Thames region, one of the most valued features of the mentoring scheme was 'the unbiased and neutral role of the mentor, with the crucial absence of any 'report back' function.'[16] The benefit derived from this set-up was that problems and concerns relating to organisational and clinical matters could be discussed openly. Furthermore a link was established between 'effective outcomes of mentoring interventions and the mentee's reliance on the confidentiality of information shared with the mentor.'[16] These aspects highlight the unequivocal benefits of confidentiality. It should be noted that the GMC provides guidelines for doctors on confidentiality titled *Confidentiality: Protecting and providing information*.[17]

8 Mentoring should be promoted as one way to improve retention within the profession.

The retention of doctors is increasingly becoming a high profile issue, largely because of the high costs associated with training. A report recently published by the BMA outlines some of the concerns of doctors who leave the profession. It suggests that three per cent of doctors leave the profession in the first six years following graduation – approximately 135 doctors a year at a cost of £34 million in training. Within this group of doctors, many indicated some interest in returning. 'In order to return they would need to be met with understanding, training and support … The key to attracting doctors back to the professions would be a culture change which would mean that staff feel that they are valued.'[18] Amongst the recommendations made to facilitate this support was that 'there should be widespread use of mentoring schemes to offer ongoing support for doctors.'[18] This is seen as integral in conjunction with doctors having a confidential advocate who does not have a direct influence on their position.

9 Aims and objectives of mentoring schemes should be clearly defined.

Mentoring schemes need to have a defined target group, clear objectives and provision for training. Furthermore, an implementation strategy should be developed. Participants in a mentoring relationship need to also be aware of their limitations, for example,

time. Some mentoring partnerships discuss terms before commencing the relationship to manage expectations and enhance the relationship.

Setting clear aims and objectives is especially important given the wide scope of mentoring definitions used. For example a GP retainer scheme in Scotland aims 'to maintain and develop their skills and thus to enable them to return to a permanent post.'[19] This means that the mentoring scheme can be established and implemented to fulfil that aim.

10 Specific programmes need to be better targeted and marketed.

There are specific mentoring schemes established for refugee doctors, GPs, women doctors, doctors in difficulty and consultants. Doctors need to be made aware of these schemes and about their potential contribution and participation as mentors and mentees. Some of the specific programmes are identified through the postgraduate deaneries. Others are often found through medical schools, royal colleges or individual trusts. Furthermore, there are specific mentoring schemes that are coordinated outside the direct sphere of doctors which encourage their participation, for example the Scottish Leadership Foundation.[20]

11 Training needs should be met for mentors and mentees.

Although training can often be perceived as an additional burden, training for participants in a mentoring relationship is important. For example, the Director of the European Mentoring Centre suggests that 'without training, only three out of 10 mentoring relationships will have a positive result. With training you can double that, and if you train both the mentor and the mentee you can get that success rate up to nine out of 10.'[14] This clearly indicates the value in training.

There are benefits to helping both the mentor and mentee prepare for their role and develop the necessary skills. For example it can define the boundaries of the relationship and expectations of mentoring so that it is realistic. Furthermore, training for mentoring is often accredited for CPD that can be of added value to doctors.

12 Mentoring schemes need to be improved based on feedback and monitoring. Results need to be shared and marketed.

Understandably, problems in mentoring schemes can arise. Some of the most common obstacles within the context of mentoring are lack of time[7] and poorly matched pairs.[15] This reiterates the importance of

having a strongly supported programme. Monitoring and evaluation are essential mechanisms that can strengthen the effectiveness and success of a mentoring scheme.[7] Additionally, sharing results can be beneficial. Important lessons can be drawn from other organisations' experiences. This is effective in terms of sharing resources and may reduce the individual time commitment.

Summary of recommendations

1 **Access to mentoring should be encouraged at all levels throughout ones' medical career.**

2 **Mentoring should be encouraged through structured and flexible frameworks.**

3 **Mentoring should remain voluntary.**

4 **The mentoring process should be continually supported by the relevant organisation/employer.**

5 **The potential advantages associated with mentoring need to be raised so doctors are more willing to participate.**

6 **A wider range of information should be offered to doctors in terms of the potential benefits and limitations of participating in a mentoring scheme.**

7 **Confidentiality should be respected and protected.**

8 **Mentoring should be promoted as one way to improve retention within the profession.**

9 **Aims and objectives of mentoring schemes should be clearly defined.**

10 **Specific programmes need to be better targeted.**

11 **Training needs should be met for mentors and mentees.**

12 **Mentoring schemes need to be improved based on feedback and monitoring. Results need to be shared and marketed.**

Conclusion

The BMA will continue to encourage participation and support of mentoring schemes. It is clear that mentoring needs to be valued in the context of time and budgetary considerations. Further to the publications and involvement described above, the BMA's Doctors for Doctors unit is an additional sign-posting resource for doctors. Moreover, the BMA in its capacity as a membership organisation will continue to lobby and liase with deaneries and trusts for mentoring to be more efficiently resourced.

Sign-posting

The BMA webpages provide a list of resources for further reading. (www.bma.org.uk)

Below is a list of resources categorised for convenience. We hope that it is helpful in learning about mentoring and finding a scheme that may be suitable. It also offers information about the best method of establishing and further developing a mentoring scheme.

Specific mentoring programmes for doctors

Evaluation of mentoring schemes

Connor M P, Bynoe A G, Redfern N, Pokora J & Clarke J (2000) Developing senior doctors as mentors: A form of continuing professional development. Report of an initiative to develop a network of senior doctors as mentors: 1994-99. *Medical Education*, **34:**747-53.

Dancer J M (2003) Mentoring in healthcare: theory in search of practice? *Clinician in Management* **12:**21-31.

Freeman R (1997) Information shared in mentoring must remain confidential. *British Medical Journal* **314:**149. (letter)

Health policy and economic research unit (2004) *Why do doctors leave the profession?* London: British Medical Association.

Murphy J (2003) *Can medical students teach senior doctors? Report on a unique reverse mentoring project.* http://www.londondeanery.ac.uk (accessed Dec 2003)

Oliver C & Aggleton P (2002) Mentoring for professional development in health promotion: A review of issues raised by recent research. *Health Education* **102(1):**30-8.

Oxley J (ed) (1998) *Supporting doctors and dentists at work: An enquiry into mentoring.* London: SCOPME. http://www.ncssd.org.uk (accessed May 2004)

Ramanan R A, Phillips R S, Davis R B, Silen W & Reede J Y (2002) Mentoring in medicine: Keys to satisfaction. *The American Journal of Medicine* **12:**336-41.

Snell, J (1999) Head to head. *Health Service Journal* **109**:22-5.

Thornett, A, Chambers R & Baker M (2003) Keeping doctors in general practice. *British Medical Journal* **327:**145-146. www.bmj.com (accessed Nov 2003)

Practical guidance on establishing a mentoring scheme / how to use a mentor

Academy of Medical Royal Colleges, COPMeD (UK), COGPED, COPDEND (2000) *A Guide to the Management and Quality Assurance of Postgraduate Medical and Dental Education.* http://kssdeanery.ac.uk (accessed Jan 2004)

Bould J (1996) *Mentoring in medicine: The practical guide.* Leeds: CCDU Training and Consultancy.

Centre for Primary Community Care Learning (CPCCL) (2004) *Primary Care Choices.*
http://www.primarycarechoices.org (accessed Jan 2004)

Crainger C (2002) Mentoring, supporting doctors at work and play. *British Medical Journal* **324:** 203.

Cygnus (2004) *Cygnus: Mentoring and professional development.* http://www.cygnusmentoring.co.uk (accessed Jan 2004)

Department of Health (2002) *Improving Working Lives for Doctors.* London: Department of Health. http://www.dh.gov.uk (accessed June 2004)

General Medical Council (2000) *Guidance on good practice. Confidentiality: Protecting and providing information*.
http://www.gmc-uk.org (accessed Feb 2004)

General Medical Council (2003) *Revalidation.*
http://www.gmc-uk.org (accessed Dec 2003)

Oxley J, Fleming B, Golding, Pask H & Steven (2003) *Mentoring for doctors: Enhancing the benefit.* http://www.ncssd.org.uk (accessed May 2004)

Oxley J, Fleming B (2004) *Mentoring for doctors: Sign-posts to current practice for career grade doctors.*

Scottish Leadership Foundation (2004) www.slfscotland.com (accessed Jan 2004)

Targeted programmes

Royal College of Obstetricians and Gynaecologists (2002) *Advice on returning to clinical work after a period of absence.* http://rcog.org.uk (accessed Jan 2004)

Royal College of Obstetricians and Gynaecologists (2003) *Mentoring Scheme Launched for Doctors in Difficulty.* http://rcog.org.uk (accessed Jan 2004)

Scottish Council for Postgraduate Medical and Dental Education (2003) *The GP Retainer Scheme in Scotland.* http://www.show.scot.nhs.uk (accessed May 2003)

Sullivan PB & Baum, D (2003) *International Projects*, Royal College of Paediatrics and Child Health. http://www.rcpch.ac.uk (accessed Jan 2004)

Overseas / refugee doctors

British Medical Association (2003) *Refugee doctors: A BMA briefing paper.* www.bma.org.uk (accessed Jan 2004)

Goraya A (ed) (2002) *A guide for refugee doctors (4e).* London: Jewish Council for Racial Equality.

Gupta R & Lingam S (2000) *Mentoring for doctors and dentists: Mentoring in medicine.* Oxford: Blackwell Science.

Medical Students

School of Clinical Medicine (2003), *Learning Support,* University of Cambridge. http://www.medschl.cam.ac.uk (accessed Jan 2004)

School of Medicine, *Compulsory and Optional Modules for Taught Postgraduate Programmes within the School of Medicine*, University of Leeds. http://www.leeds.ac.uk (accessed Jan 2004)

University of Southampton, *Education Development Unit Newsletter,* 2001. http://www.som.soton.ac.uk (accessed Jan 2004)

Training grade

Eastern Deanery (2003) *The Pre-registration year: Guide and record of progress and assessment.* http://www.camdent.org.uk (accessed Dec 2003)

Oxford Department of Postgraduate Medical and Dental Education (2002) *Annual Report 2001-2002*. http://www.oxford-pgmde.co.uk (accessed Jan 2004)

University of Southampton (1999) *Education Committee of the GMC Report of the visit to the school of medicine and to the Wessex Deanery, 7-8 December 1999*. http://www.som.soton.ac.uk (accessed Jan 2004)

Career grade doctors

Faculty of Public Health Medicine (2002) *Lifelong learning: The second cycle of CPD for public health.* http://www.fphm.org.uk (accessed Jan 2004)

Faculty of Public Health Medicine (2001) *The Newsletter of the Faculty of Public Health Medicine* **3(1)** http://www.fphm.org.uk (accessed Dec 2003)

Oxley J (ed) (1998) *The Educational Needs of GP Non-Principals,* London: SCOPME.

Training and support materials

Cygnus (2004) *Cygnus: Mentoring and professional development.* http://www.cygnusmentoring.co.uk/home.html (accessed Jan 2004)

Faculty of Medicine (2003) *Policy on Training for Supervisors.* University of Glasgow. http://www.gla.ac.uk (accessed Jan 2004)

The Oxford School of Coaching and Mentoring (2003) *The Coach-Mentoring Consortium.* http://www.oscm.co.uk (accessed Dec 2003)

Smith C (2002) *Improving the management and training: developing a calendar of key clinical skills and responsibilities training alongside a mentor scheme*, Supported by the North West Deanery / Department of Postgraduate Medical and Dental Education Under the Blending Service with Training Initiative.

University of Wales College of Medicine (2003) *GP PRHO Posts.* http://www.uwcm.ac.uk (accessed Jan 2004)

Studies and examples of mentoring (from other sectors)

Conway C (1994) *Mentoring managers in organizations: A study of mentoring and its application to organizations with case studies.* Herts: Ashridge Management Research Group.

Ehrich L, Tennent L & Hansford B (2002) A review of mentoring in education: Some lessons for nursing. *Contemporary Nurse* **12(3):** 253-64.

Incomes Data Services (1996) *Mentoring Schemes.* Study 613, London.

Incomes Data Services (2000) *Personnel policy and practice: Mentoring.* Study 686, Surrey: Unwin Brothers, The Gresham Press.

Ragins B R & Cotton J L (1999) Mentor functions and outcomes: A comparison of men and women in formal and informal mentoring relationships. *Journal of Applied Psychology* **84(4):** 529-30.

Walsh A M & Borkowski S C (1999) "Cross-Gender Mentoring and Career Development in the Health Care Industry," *Health Care Management Review* **24:** 7-17.

Appendix A – Responses from Deaneries

The table below outlines the themes generated from the responses received. The BMA wrote to 25 postgraduate deans. Fourteen provided responses generating a response rate of 56 percent. The results are consistent with other research findings highlighting the wide spectrum of the types, range and scope of mentoring programmes available.

The variation highlighted by these responses indicates that there is not enough being done. It strengthens the recommendations in this report and urges greater attention and commitment to mentoring.

Theme	**Number of Deaneries who identified these schemes**
Not centrally co-ordinated by the deanery	2
Ad hoc projects	2
Targeted schemes	
Consultants	4
GPs	5
Overseas and international doctors	1
Refugee and asylum seeking doctors	1

Contact details for postgraduate deaneries can be found in *Sign-posting medical careers for doctors* which is available on the BMA website.

Appendix B – The GMC's use of mentors for addressing performance problems

If there are serious concerns about a doctor's professional performance, they may be referred to the GMC's performance procedures. If after a full assessment there are serious concerns, they may be asked either voluntarily to accept the imposition of some detailed "requirements", or they may appear before the Committee for Professional Performance and have conditions imposed on their registration. In both of these situations they may be advised to contact a postgraduate dean who may be able to put them in contact with a doctor who is willing to act as their mentor. This mentor helps the doctor produce a personal development plan to guide their retraining and personal professional development. In this situation the doctor (mentee) is aware that their professional registration will be restricted until they have satisfied the GMC that they have fulfilled the undertakings and complied with any conditions imposed including the requirement to seek a mentor and make regular contact with the mentor.

The relationship with a mentor is required as part of the process of retraining. The mentor will have volunteered to undertake this role and may or may not be paid. The mentee may ask the mentor to report on their contacts and on the doctor's progress. They may also ask them to attend a GMC hearing and to give evidence on oath. If the mentor agrees to do this, they are not there to act as an advocate for the doctor, but they are asked to exercise their professional judgement and respond honestly. At the hearing they may be questioned and cross-examined by the lawyers representing the doctor and the committee.

References

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