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PROFESSIONAL DEVELOPMENT IN GENERAL PRACTICE

EDITED BY
DAVID PENDLETON AND JOHN HASLER

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achievement at school is followed by the potentially stressful acquisition of a large knowledge mass in preparation for the final qualifying examinations. Even before Vocational Training became compulsory in 1981, it was accompanied by financial inducement in the form of the Vocational Training Allowance. One of the effects of summative or end-point assessment will be to reinforce external motivation to learn. A young doctor taking his first steps as an independent practitioner may well cling to the familiar educational culture, that is, being *told* by expert specialists.

Many entrants to general practice during the last 25 years will have experienced aspects of a mentoring relationship with trainers who have attempted to engender trust, to encourage lifelong learner-centred, self-directed learning, and to offer professional and personal support. But, the experience of this type of relationship is not universal and many, who entered general practice before 1977, had no formal general practice based education. This is not to suggest that these GPs, as a group, are not well developed practitioners who take their responsibility for self-directed learning very seriously, rather that *some* may have difficulties, having been *conditioned* by the specialist undergraduate teachers to consider 'keeping up to date' as beyond their grasp. Furthermore, some experienced GPs will find the idea of mentoring more familiar than others. Even those who have regarded their trainers as mentors need to make adjustments. A hierarchical gap, however small will have existed — the trainee has been 'allowed' to treat the patients of a senior doctor, who has retained overall responsibility, and has to certify the trainee's educational achievement as satisfactory.

Against this background, several qualities of the relationship between GP and mentor emerge.

1. Trust
   In their relationship, an autonomous GP must trust his* mentor to have only his interests at heart. He must believe that their discussions are confidential, that is, they will not provide gossip and will not be used to put the GP's livelihood at risk, for example in re-accreditation.
2. Empathy
   The GP and mentor must have a shared understanding of the job. GPs may believe that only another GP will have sufficient understanding to act as his mentor.
3. Learner centredness
   The mentor will need the humility to believe that others have experiences and insights into the job just as valid as her* own and that their learning and development will occur by reflection on these experiences and insights and subsequent experimentation.
4. Wisdom
   The GP must perceive the mentor as bringing sufficient 'wisdom' to the relationship to make it fruitful, but without hierarchical distance. *Athene*

* For brevity alone, the female gender of the force behind the original *Mentor (Athene)* is used and the traditional male gender of the GP.

assumed the form of the original *Mentor* to the same end. The mentor will often require seniority and reputation, but the ability to understand and make sense of the GP's ideas may be seen as an indication of wisdom.

The 'Transformational Journey' of a GP's professional lifetime of 30 or 40 years may be considered to involve at least three interdependent areas of change.

1. Development of scientific knowledge — 'recent advances'
   Important though many medical discoveries have been to general practice, the traditional 'family doctor' role of the first part of the century seems to be valued (and sometimes missed) by many patients
2. Changes of the place of the profession in a developing society
   The profession of medicine developed from apothecaries and barber surgeons, gaining its status in the eighteenth century. Patient awareness and more recently consumerism may be seen as threatening this, although the status of British general practice within the medical profession has increased considerably during the last 40 years.
3. Movement through the stages of a personal life
   The personal changes experienced during a professional lifetime — marriage, parenthood, loss of parents, and preparation for retirement — are surely more intense than changes in medical knowledge or society.

Cartwright (1967) reports GPs' expressions of tedium of their work suggesting a paucity of external change. Maybe GP mentors should see themselves as helping to guide *personally changing* practitioners through relatively static professional demands.

. . .Our old life is still there, but its meaning has profoundly changed since we left home, seen from afar, and has been transformed by that vision.

(Daloz)

AN EXAMPLE OF GP MENTORING: THE SOUTH EAST THAMES PROJECT

In 1989, ten GPs were appointed as mentors to be linked to half of the twenty postgraduate centres in the South East Thames Health Region, an area which encompasses the counties of Kent, East Sussex, and the South East quadrant of London. This would be an experimental group of GPs who would assist both the organizers and providers of CME within the region, and those to whom it was aimed — established GPs. Each mentor would relate to the GP tutor and others involved with CME in the Health District: Clinical Tutor, RCGP Tutor, in and outside the Postgraduate Centre. He or she would have the task of offering to visit *each* of the one hundred or so GPs in the district, to spend about one hour facilitating the GP's own identification of learning needs, and to provide him with a written summary of their meeting. The mentor's prime task would *NOT* be to provide detailed information to the providers of courses,

Table 10.5 Doctors' current involvement in CME

Activity	% involved
Reading medical journals	84%
Attending local meetings/courses with colleagues (eg Young Principals groups, 'clubs', 'societies')	63%
Attending meetings at the local PG Centre	53%
GP Trainer (local PGC and/or trainee-practice)	45%
Attending clinical practice meetings with partners	37%
Attending residential/short courses outside region	35%
Attending drug company presentations or sponsored meetings	12%

STEP-BY-STEP GUIDE

1. Preparation

(a) Aims

The organizers will need to agree the general ethos of the service, although the mentors should gradually develop personal and group understanding of their role within this ethos. As discussed in the first section, mentors in other professions have been involved in appraisal. However, in the project described, the aim was to help the GP to reflect on the content and style of his learning needs and to help him discover barriers to meeting them. The mentors attempted this by summarizing one hour lightly structured interviews with individual GPs. Because the barriers to learning might be of a confidential or personal nature, the process required that the mentor should be trusted by the GP. If a similar project were to offer repeated interviews, the ethos would also include the mentor's trust that the GP would wish to meet these educational needs (or developments of them) without the need for their formal review.

(b) Funding

This is considered in detail later.

(c) Liaison

The organizers should take care to liaise with other GP professional bodies that may consider aspects of the mentor's role to be their own. To aid planning, GP tutors may be assessing the GPs' learning needs in similar or different ways. Broad definition of learning and education by mentor may impinge on the pastoral support offered to local GPs by the Local Medical Committee, local British Medical Association division, or the faculty of the Royal College of

General Practitioners. Certainly a mentor with this view will need to be aware of such local resources.

(d) Publicity

If the mentors are to be selected as peers of the GPs who will be offered the service, the latter should be aware of the aims of the service before applications for the posts are sought. Rumour, speculation, and misinformation are almost inevitable as the project starts, but attempts to minimize the perceived threat to GPs may be assisted by the liaisons mentioned above.

2. Appointment

The organizers will need to decide on the degree of peer GP involvement in the mentoring service. A shared understanding of the GP's job may encourage trust, but others, such as educationalists or psychologists may have better counselling skills and educational knowledge. It is likely that both groups will be represented in the organizing group. The organizers should explore ways of encouraging female applicants to apply, perhaps by talking with female GP groups.

The list of desirable mentor qualities agreed by the South East Thames group is comprehensive.

- experience
- local knowledge
- reputation
- adaptable but non-judgemental listening style
- ability to summarize and organize
- enthusiasm, optimism, and resilience

They would have welcomed an interview by an experienced mentor before 'signing on'.

3. Training and support

At the start of the project, the agendas of the new mentors and the organizers are likely to require a one to two day meeting. They may include:

- Formation of the group
- Introduction to interviewing/counselling skills
- Exploration of the mentor's role
- Confidentiality and responsibility
- Practical issues, e.g. agreement of forms, how to approach GPs

The mentors described were encouraged to develop a group understanding of their role. They discussed this repeatedly at quarterly half-day support meetings, particularly in terms of the breadth of the definition of education — their boundaries — and how much advice they should offer. At these meetings they also shared problems of access to GPs, conducting the interview and report

writing. They expressed feelings of isolation and lack of motivation between the meetings and probably this interval should not be exceeded. A newsletter and local sub-groups, particularly if several mentors are appointed to a district, might reduce the potential for isolation. Eventually, an experienced group of mentors is likely to gain the confidence to develop and treasure individual styles.

Report writing is both time consuming and foreign to most GPs. However, it was central to the project described. The GPs interviewed commented on the value and accuracy of most reports, but the reports also served to heighten the mentors' understanding of general practice, professional education, and the mentoring process. Feedback from both GPs and mentors was used as research data, but it too seemed to assist mentor development.

4. Access to GPs

Careful continued publicity and liaison should lessen the threat of an approach by a GP mentor. News of the successful (and unsuccessful) interviews will be spread by word of mouth. However, the inducement of Postgraduate Education Allowance credits may encourage some GPs to 'take the plunge'.

5. Funding

The South East Thames mentors used at least three hours for arranging, travelling, undertaking, and writing up a one hour GP interview. Some achieved three interviews during two half day sessions. Five half days each year for training and support seems a bare minimum. A mentor probably needs a minimum concentration of experience of one interview each month to allow training and development. Although a single mentoring experience has been shown to be acceptable to GPs, most mentors and many GPs expressed the wish for a second visit within a year or two. Several GPs said they would have preferred a choice of mentors. These estimates allow predictions of workload. For example, one hundred GPs offered a meeting with one of a choice of three mentors every year would probably involve 81 ($2/3 \times 100 + 5 \times 3$ training) half day sessions per year divided between the three mentors, or a minimum of 27 each. It is of course possible that the annual visit would represent an average, that some GPs would wish more frequent contact, some less.

As previously stated, the mentors gained insights into general practice and professional education. These insights might be considered valuable preparation for future organizers of CME. Such insights could also be used by trainers in preparing their trainees both for life-long learning as GP principals and for the variety of general practice outside their own training practices. 'Fallow' GP Trainers may be considered as a group of potential mentors. Perhaps an FHSA might consider funding a pilot scheme on this basis.

6. Evaluation

Outcome measures for general practice are notoriously difficult. Those aspects that are easily evaluated objectively, often involving preventative measures, referrals to hospital, and prescribing are not necessarily those of most importance to the patients; those in *Schön's* 'swampy lowland of practice'. Clearly the difficulties extend to evaluating the effect of a mentoring service on these outcomes. The attempts at overcoming these difficulties for possible *re-accreditation and re-certification* may allow investigation of effects of a mentoring service, but as stated above, mentors risk destroying their GPs' trust and confidence, if they are seen to be participating in this type of assessment. The prime function of accreditation or re-accreditation seems to be the protection of an unsuspecting public from GPs they are unable to identify as so seriously deficient that they should lose their professional autonomy. Professional development is based upon this autonomy. Mentors will help those who feel threatened by the assessments, and those failing them, but they should never be seen as 'policing' them.

Portfolio-based learning

Clearly the qualities and roles of the mentor in portfolio-based learning are similar to those described in Chapter 8. However there are subtle but significant differences. A successful portfolio-based learning cycle involves the demonstration that agreed, defined, and planned educational objectives have been achieved. To maintain learner autonomy, self-assessment is the method of choice. The mentor encourages and facilitates the identification and achievement of the objectives. It is the *clarity* of the objectives that may distinguish the two types of mentoring. This clarity is helpful to those outside the process — the paymasters of GP and mentor, for example. But the 'Transformational Journey' is broken into small attainable steps, of necessity defined in terms meaningful before the steps are taken. The whole 'journey' often includes changes of a depth that involve a development of the way in which knowledge, medicine, and the GP's role are perceived. Obviously these changes are not excluded by portfolio-based learning, but there is a danger that during the defined learning activity this depth of change can threaten the objectivity of the portfolio and vice versa.

However, evaluation difficulties should not deter enthusiasm for the concept of mentoring which is soundly based on accepted principles of adult and continuing education. They have not deterred the continued enthusiasm of many GPs for their work which is no less resistant to evaluation.

REFERENCES

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