

# Exploring the relationship between engagement in mentoring activities and doctors' health and well-being

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## Final report



## *Acknowledgements*

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## *Glossary*

**BITC:** Business In The Community Workwell model.

**Health and Well-Being:** In the context of this study, health and well-being covers any aspect of your physical, mental and social well-being. IT is encouraged to consider health and well-being broadly to encompass both work and other aspects of your life, for example, your work environment, its climate and culture; support and relationships both in and out of work (adapted from DH, 2014; WHO, 1948).

**Mentor:** In the context of this study a mentor is someone who has been trained in mentoring

**Mentee:** In the context of this study a mentee is someone who meets with a mentor for discussions about an issue or opportunity they have.

**Mentoring:** For the purpose of this study ‘mentoring’ refers to a relationship between a trained mentor and a mentee. The trained mentor uses a range of skills and frameworks taught on mentor preparation courses (Egan, 2007, Connor & Pokora ,2007). The mentor helps the mentee: take charge of their own development and release their potential; unpick issues and/or opportunities; develop and examine their own ideas; set and achieve results that they value (adapted from Connor & Pokora, 2007; SCOPME, 1998; GMC, 2012; GMC, 2014). For the purpose of this study mentoring does not include informal protégé/mentor relationships based upon sponsorship and patronage.

## Contents

Background .....	5
Aim .....	7
Methodology.....	7
Part 1: An exploration of published literature .....	10
Search strategy.....	10
Findings .....	13
Thematic synthesis of findings .....	16
Conclusions .....	18
Part 2. Questionnaire Survey .....	20
Aim .....	20
Questionnaire development .....	20
Data analysis.....	26
Findings .....	27
Part 3: A prospective case study tracking the impact and influence of mentor training and mentoring activities on health and well-being .....	42
Aim .....	42
Data management and analysis .....	45
Findings .....	48
Theme 1– Mentorship as a vehicle for better specialist support .....	49
Access to mentorship.....	49
Engagement with mentorship.....	51
Mentorship enactment .....	53
Mentorship as support.....	55
Composite vignette .....	56
Theme 2 - Mentorship supporting better personal and professional relationships .....	57
Relationship Issues brought to Formal Mentoring .....	57
Informal application of mentoring skills to relationships .....	58
Developing Collegiate relationships.....	59
Composite vignette .....	60
Theme 3– Mentorship supporting better professional and personal well-being.....	61
Threats to wellbeing.....	61
Mentoring Responses to wellbeing threats .....	62
Mentoring Impacts on wellbeing .....	64
Composite vignette .....	67
Theme 4 – Mentorship Supporting Better Working communities and cultures .....	68
Perceptions of existing communities and cultures .....	68
Mentoring mitigating unsupportive workplace cultures & communities.....	69
Mentoring enhancing culture, community and care .....	70
Extending out to the wider community of patients.....	72
Composite vignette .....	73
Discussion and final remarks .....	75
Overarching model: .....	75
Key issues .....	77
Final remarks.....	85
Study Limitations .....	86
References .....	87
Appendices.....	93
Ethics approvals .....	93
Email correspondence .....	94
Dissemination .....	96

Figure 1: Study design .....	8
Figure 2: Systematic search strategy .....	12
Figure 3: Questionnaire contents .....	21
Figure 4: Email distributed to participants .....	26
Figure 5: Issues brought to mentoring sessions regarding better relationships .....	30
Figure 6: Issues brought to mentoring sessions regarding better physical and psychological health .....	31
Figure 7: Issues brought to mentoring sessions regarding better work .....	33
Figure 8: Perceived influences of being involved in mentoring for mentees and mentors) .....	34
Figure 9: Extent to which involvement in mentoring affects doctors' health and well-being) .....	35
Figure 10: Extent to which mentoring leads to a supportive environment) .....	36
Figure 11: Perceived impact of mentoring on mentors health and well-being .....	37
Figure 13: Perceived impact of mentoring on mentors' physical and psychological health .....	38
Figure 14: Perceived impact of mentoring on mentors' better work .....	40
Figure 15: Mentoring as a vehicle for better specialist support .....	76
Figure 16 : The relationship between availability, access, perceptions and context upon mentoring activity .....	78
Table 1: The PICO framework to develop a search strategy used for the systematic research .....	10
Table 2: Inclusion criteria of systematic search .....	11
Table 3: Details of research papers retrieved from the systematic search .....	14
Table 4: Details of non-research papers retrieved from the systematic search .....	15
Table 5: Demographic data of questionnaire respondents .....	27
Table 6: Number of mentees .....	28
Table 7: Number of 'one-off' mentoring sessions .....	29
Table 8 : Interview numbers .....	42
Table 9 Interview preparation document .....	43
Table 10 Semi structured interview guide .....	43
Table 11: Interview themes and categories .....	48

## Background

There is a strategic focus upon the health and well-being of healthcare professionals<sup>5, 6</sup> perhaps partly fuelled by the recognition that *‘without strong employee well-being, employee engagement declines, retention suffers, and motivation and performance are affected’*<sup>7</sup>. Health and well-being are recognised as varied, and complex, components which are unique to individuals and related to their contexts and situations. Health and well-being are known as ‘fuzzy concepts’ incorporating a range of elements and definitions. Rather than merely the absence of illness, health can be defined as *‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’*<sup>8</sup>. No definition of well-being is universally accepted and the term is often used to encompass various health-related subtleties. Well-being is thought to include both traditional objective components of health, as well as more ‘subjective’ or personal attributes. Objective components are concerned with meeting basic societal human needs whilst subjective components of well-being involve the individual’s thoughts and feelings regarding being satisfied (evaluative), feeling positive emotionally (hedonic) and considering one’s life has meaning (eudemonic)<sup>3</sup>. Low levels of subjective well-being have been associated with increased anxiety and depression, whilst high-levels of subjective well-being are considered to reduce morbidity and mortality<sup>6</sup>. Antonovsky’s theory of Salutogenesis suggests that a person’s sense of coherence and meaning helps an individual to cope with adversity and life stresses and is similar to notions of resilience or health assets, including internal strengths (relational, motivational, protective and volitional) and external strengths (support, expectations of others and environmental elements)<sup>7,8,9</sup>. Dodge, Daly<sup>9</sup> proposed a definition of well-being as a state in which *‘individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge’*<sup>9</sup>. The BITC Workwell model<sup>2</sup> incorporates physical, psychological and social components of health and well-being. It suggests that to create a healthy environment and to support the health and well-being of employees, these components must act together. The BITC Workwell model promotes a cycle of business activity which incorporates better physical and psychological health, better work, better specialist support and better relationships to promote working well<sup>2</sup>.

The NHS is undergoing organisational transition, as it seeks to improve care and service quality to meet increasing public and political expectations. This is being done within an environment of financial restraint and increasing levels of professional accountability<sup>10, 11</sup>. Such change increases demands on, and stresses for, its employees. Over the past few years, reports have consistently highlighted several work-related challenges impacting upon NHS staff and doctors’ work-life balance, work morale and stress levels<sup>12, 13</sup>. In 2010 the Department of Health outlined<sup>6</sup> the extent of health-related needs of health care professionals, suggesting stressors associated with the nature, structure and organisation of health-related work had negative impacts upon the health and well-being of those involved. In 2012 the NHS Practitioner Health Programme’s (PHP) third annual report<sup>13</sup> charted the health issues of doctors who had accessed the PHP service, many involving multiple co-morbidities: 85% had a mental health problem, 28% had an addiction problem, and 17% had a physical health problem. The following 5-year PHP overview<sup>13</sup> confirmed consistency of findings with averages across the years indicating around 80% of those accessing the service had mental health problems and 20% had an addiction problem.

Indeed it has been suggested that doctors are more likely to experience work-related mental ill-health than other professions in the UK and internationally<sup>14</sup> and previous reports have suggested that up to 28% of practicing doctors report symptoms consistent with a psychiatric illness and that the suicide rate in doctors is up to twice that of the general population<sup>15, 16</sup>. A recent study based on reports by psychiatrists also found a higher incidence of work-related mental ill-health reporting in doctors in comparison to other occupations<sup>17</sup> and postulated that this could have repercussions for quality of care and patient safety.

The 2015 NHS staff survey reported that the percentage of staff suffering work related stress in the previous 12 months had risen to over 35%<sup>18</sup>. In the recent BMA survey of views from across the medical profession for the 3<sup>rd</sup> quarter of 2017 43% of respondents described their morale as being low or very low<sup>19</sup>. This is also reflected in a 2016-17 morale and welfare survey undertaken by the Royal college of Anaesthetists in which respondents ranked maintaining a work/ life balance as foremost in the top ten factors negatively contributing to morale<sup>20</sup>. This concurs with a recent general independent review of mental health and employers<sup>21</sup> which stated that *'the UK is facing a mental health challenge at work that is much larger than we had thought'* and indicated that poor mental health costs the UK economy between £74 billion and £99 billion a year. However, this phenomenon is not solely the domain of one specialty or confined to a specific point in a medical career. A cross sectional study of 'grit' and burnout in UK doctors<sup>22</sup> indicated that GPs had comparatively high levels of overall burnout, disengagement and exhaustion scores. While a recent GMC survey reported that work intensity was an issue both for trainers and trainees with almost 25% of trainees feeling short of sleep while at work on a daily or weekly basis and just over 40% rated the intensity of their work as 'heavy' or 'very heavy'<sup>23</sup>. A survey of anaesthetists in training also recently reported 64% of participants felt their job had affected their physical health, and 61% felt a negative impact on their mental health<sup>20</sup> (pg.1). Thus health and welfare issues related to medical practice and work life appear to cross specialities, sectors and career trajectory.

Mentoring schemes may be one way of helping doctors at all stages of their career cope with difficulties, transitions and related expectations<sup>25</sup>. Kram<sup>26</sup> identified broad functions of mentoring as including career functions and psychosocial functions. Within medicine and healthcare there is a growing literature<sup>27-31</sup> that suggests being involved in mentoring programmes carries benefits for both mentees and mentors. Such benefits implied within the literature cut across the professional and personal interface and include professional practice, personal and professional development, as well as personal health and well-being<sup>28</sup>. The BMA supports mentoring within medicine, but much research has explored organised mentoring activities such as mentor and mentee interaction, highlighting roles, functions, benefits and challenges<sup>27, 36-38</sup>.

However, there has been limited focus on doctors who have attended mentor training and how they subsequently employ these mentoring skills and abilities and the impact this has on doctors' health and well-being. This study was funded by the BMA through the Joan Dawkins research award 2014 in order to explore those relationships.

## Aim

By exploring the relationship between engagement in mentoring activities and doctors' health and well-being, this study set out to develop our understanding of the potential impact and value of mentoring within the workplace.

## Objectives

- To retrospectively identify, describe and assess links and relationships between mentoring activities and health and well-being through:
  - i. Reviewing mentoring literature relating to medicine to identify reported relationships between mentoring activities and doctors' health and well-being.
  - ii. Surveying a sample of doctors with experience of using mentoring to ascertain their perceptions of any relationship between mentoring skills and activities and health and well-being.
- To identify and deconstruct, as far as possible in real time, engagement in mentoring activities and the impacts on doctors' health and well-being through,
  - i. Tracking over a two-year period (via a series of interviews) a sample of doctors who have recently undertaken preparation (education and /or training) to be a mentor.
- To develop case trajectories and exemplars which highlight the main findings and the interplay between factors through
  - i. The analysis of individual data sets and comparative analysis across data sets
  - ii. The collection of real life examples and illustrations of links, key factors and relationships. These data will be gathered both retrospectively and prospectively.

## Methodology

This study is based upon the view that both education (e.g. mentor development programmes) and support activities (e.g. mentoring activities) are complex social processes which take place in complex settings. In relation to education seminal work by <sup>39</sup> (pg.13) described the learning environment as an:

*'interrelated whole including, social, cultural, institutional, psychological and historical variables which interact to produce a unique pattern of circumstances, pressures, customs, opinions, and work styles which suffuse the teaching and learning that occur'*

Furthermore, given the complex, very individual and context-bound nature of mentoring<sup>29</sup> it would be difficult to objectively identify and measure mentoring outcomes using a traditional science approach. Perhaps more important at this point in the development of our knowledge base, is the description and exploration of the experiences of those involved in order to begin to unpick any relationships which seem to exist, and what works, best for whom and under what circumstances.

Therefore, the study employed multiple methods drawing on the principles of Realistic Evaluation<sup>40</sup> to explore the relationships between involvement in mentoring activities and doctors' health and well-being. Based in critical realism, realistic evaluation<sup>40, 41</sup> views social reality as complex and multi-layered. By comparing what works, for whom, and under what circumstances, commonalities and variations across mechanisms (the individual and process), contexts (environmental factors) and outcomes (perceptions and experiences of health and well-being) are identified, described and explored. Therefore, associations between mentoring activity, contextual factors and well-being outcomes can be identified and critiqued, as well as associations outlined.

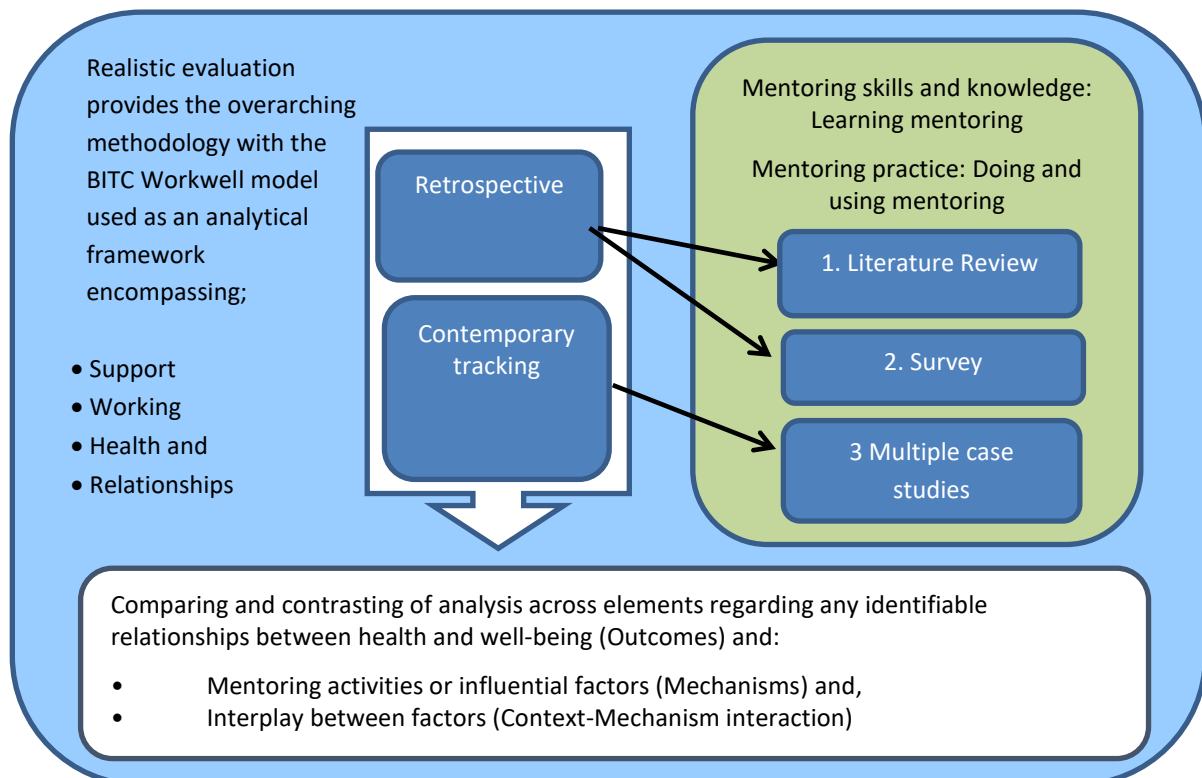
## Study design

The study was designed in two linked parts (**Figure 1**):

1. A retrospective exploration of published literature and a questionnaire survey of doctors with over two-years involvement in mentoring activities. Doctors with over 2 years of experience were chosen in order to access individuals with sufficient long term experience of mentoring to be able to offer a range of examples of mentoring relationships.
2. A series of case studies tracking doctors who had undertaken a mentor development programme within the previous two-years. This population of Doctors was chosen as it was felt they would still be sufficiently 'aware' of the new knowledge and skills attained during a mentor preparation course to be able to identify their day to day use.

In this way, the study was designed to look retrospectively for indications of any relationships and to track and understand any relationships as far as possible 'in real time'.

**Figure 1: Study design**





### Ethical and governance considerations

This project was approved by Northumbria University's Faculty of Health and Life Sciences ethics review panel (Ref: DHCSteven171014). Detail regarding recruitment, sampling and analysis for each part will be detailed in appropriate sections below.

With regard to NHS ethical approval, the NRES algorithm (requirements for REC review, version dated August 2011) states that *'REC review is not normally required for research involving NHS or social care staff recruited as research participants by virtue of their professional role'*, therefore NHS ethics approval was not required for this project. With regard to R&D NHS Trust approvals in June 2015, the HRA introduced a new process for research involving NHS staff. This process replaced previous requirements to contact and gain approval from multiple R&D departments, therefore the research the proposal was sent to the HRA who reviewed it and agreed that approval was not necessary (see appendices ).

Ethical principles were adhered to throughout. Participants were provided with study information and given at least seven days to consider participation, and ask any questions, before making a decision regarding participation. Participants were also informed that they could withdraw at any point without impact on employment or future continuing education. Interviews were audio-recorded and transcribed verbatim, with all identifying information removed. Participants were allocated a unique identifier and these along with the data files were only available to the research team. All information was kept on a password-protected University server. Sound files will be destroyed approximately three months after production of the final report and transcripts will be kept for three years in line with University policy. Participation was voluntary and all participants gave written informed consent to take part in the study and for the (anonymised) information to be used for analysis and dissemination purposes.

### *Anonymity*

Great care has been taken throughout the writing of this report to maintain the anonymity of those involved. To this end identifying codes for participants have been changed from time to time to minimise tracking and identification of participants. In addition the vignettes are composites and have been developed with the upmost sensitivity to identification of individuals.

## Part 1: An exploration of published literature

### Aim

This systematic narrative review<sup>42</sup> aimed to investigate published, peer-reviewed anecdotal and empirical evidence regarding associations between mentoring activities and the health and well-being of doctors. The methodological approach taken is recommended where the review question dictates the inclusion of a wide range of literature and research designs, producing qualitative and/or quantitative findings, for which other approaches to synthesis, such as traditional systematic reviews, are inappropriate<sup>42, 43</sup>.

### Search strategy

Search terms were developed from the research aim using the PICO framework<sup>44</sup>. The PICO framework was chosen to allow the development of precise search strategies, leading to more relevant search results<sup>44</sup> (**Table 1**).

<b>P</b> Patient or population	Doctor; Medic; Physician
<b>I</b> Intervention	Mentor; Mentee; mentoring (truncated to ment*)
<b>C</b> Comparison (if applicable)	Not applicable
<b>O</b> Outcome	Health; Well-being; Benefit; Advantage; Barrier; Impact; Disadvantage; Challenge

**Table 1: The PICO framework to develop a search strategy used for the systematic research**

Three of the four framework headings (Patient/population, Intervention, Comparison and Outcome) were used to develop the search strategy. As there was no intervention the 'comparison' aspect of the PICO framework was not applied. Conventions for accessing comparable terms were adopted, for example, the use of truncation.

To reflect the contemporary evidence base, papers published within the last decade (January 2006-January 2016) were included in the review. Established databases, most pertinent to health and education, were identified (**Table 2: Inclusion criteria of systematic search**). Within each database, search terms were used to identify pertinent articles by searching the title and abstract for key words. Only studies in the English language were included.

Studies were excluded if the sample consisted of undergraduate medical students as the structure of mentoring is more akin to supervision than mentoring here. A range of papers with an original contribution were included in the systematic search strategy, including: research papers, commentaries, discussion papers, and personal accounts. Literature reviews were excluded from this study as they did not provide original evidence and care was taken to remove multiple reference to single sources.

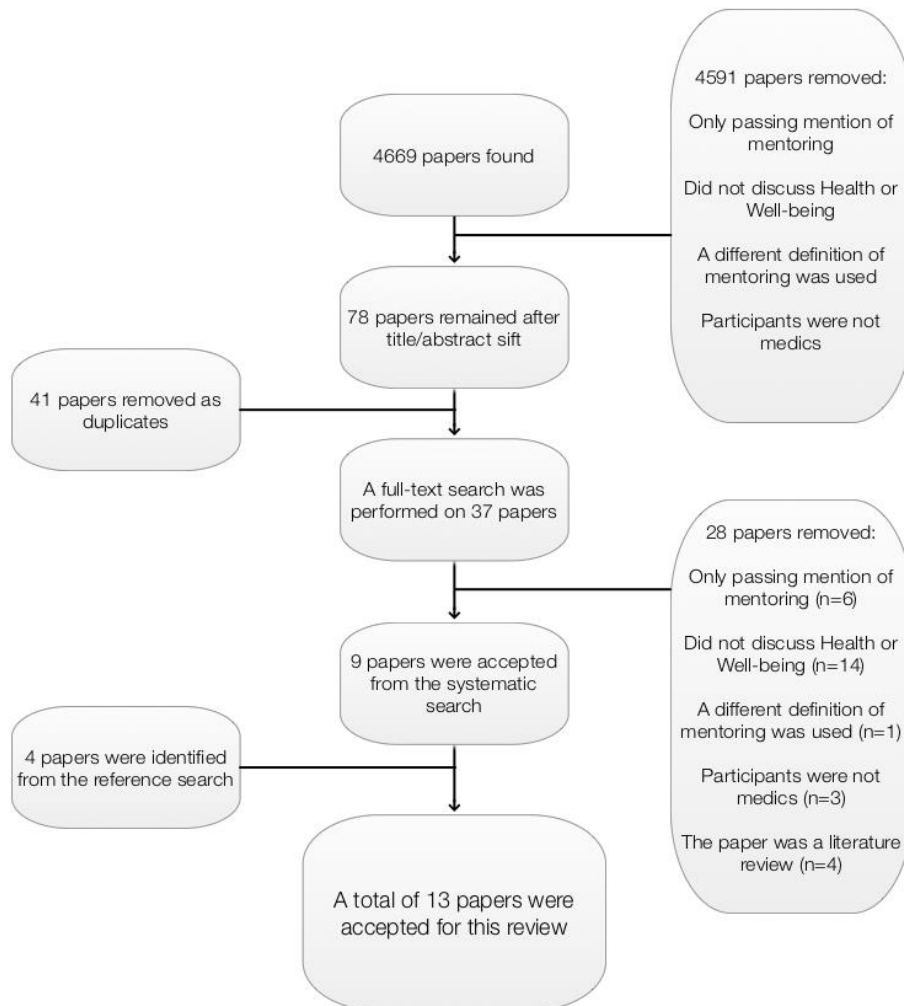
**Table 2: Inclusion criteria of systematic search**

<b>Year of publication</b>	January 2006 – January 2016
<b>Source</b>	ASSIA (Applied Social Sciences Index and Abstracts) BEI (British Education Index) CINAHL (Cumulative Index to Nursing and Allied Health literature) DOAJ (Directory of Open Access Journals) ETHOS (E-Theses Online Service) Hospital Collection Medline OpenDOAR (Open Directory of Open Access Repositories) Proquest Nursing and Allied Health Source Science Direct Freedom Collection Web of Science Zetoc
<b>Search Field</b>	Title, Abstract, Keywords
<b>Language</b>	English only
<b>Participants</b>	<b>Excluded:</b> Undergraduate medical students
<b>Search terms</b>	Ment* AND (doctor* OR medic* OR physician) AND (health OR well-being) Ment* AND (doctor* OR medic* OR physician) AND (benefit* OR advantag* OR barrier* OR impact OR disadvantage* OR challeng*)
<b>Type of paper</b>	<b>Excluded:</b> Literature reviews

Utilising the search criteria in **Table 2**, a total of 4,669 papers were identified. After removing non-English language papers and those relating to other health professions, GW read the title and abstract of all remaining articles to ensure the articles fulfilled the literature review criteria. Of these papers, 4,591 were removed as there was either only a passing mention of mentoring, the abstract did not discuss health or well-being, the definition of mentoring differed to that applied within this systematic narrative review, the paper was either a systematic review or literature review, or the sample were not medics. Seventy-eight papers remained after the title and abstract search, of which, 41 were removed as they were duplicates. The remaining 37 papers were then read in full by the research team (**Figure 2**).

To assist in reading, summarising and extracting pertinent points of the papers a data extraction pro-forma was developed and agreed by the research team. The pro-forma was based on the BITC Workwell model<sup>2</sup> and the team's knowledge and expertise of mentoring. This pro-forma aided the recording and synthesis of the characteristics of each paper, the aspects of health and well-being discussed, as well as outcomes. During data extraction, the quality of each paper was examined. This was informed by the Critical Appraisal Skills Programme (CASP) tool<sup>45</sup>. Where there were doubts about the inclusion of information a team discussion was held.

**Figure 2: Systematic search strategy**



Of the full-text articles searched, 28 were removed because there was only a passing mention of mentoring (n=6), the paper did not discuss health or well-being (n=14), a different definition of mentoring was used to the one used by this study (n=1), the paper was a literature review (n=4), or the sample were not all medics (n=3). This left nine papers which were accepted for full review. A reference and citation search was conducted on all nine papers, utilising a snowballing technique to look for relevant additional texts that were not identified in the database search. Four papers were identified from this search strategy. This provided a cumulative total of 13 papers for this review.

The accepted papers were analysed using theory-driven thematic synthesis in which the components of the BITC Workwell model<sup>2</sup> acted as a heuristic device to synthesise findings into four thematic groupings, each reflecting the components of the model; better work, better relationships, better specialist support and better physical and psychological health. GW and VL independently analysed and synthesised the papers and brought the analyses to the larger group of all authors for discussion, debate and agreement.

## Findings

### Characteristics of the papers included

Of the 13 papers included from the systematic search (**Table &4**) ten were research papers<sup>28, 46-54</sup> and three were non-research papers; one commentary<sup>55</sup>, one personal account<sup>56</sup> and one discussion piece<sup>57</sup>. Of the research papers, three used qualitative interviews to collect data<sup>28, 47, 51</sup>, although Strong, De Castro<sup>51</sup> analysed the data both qualitatively and quantitatively. One research paper used a combination of focus groups and interviews<sup>48</sup>, five research papers utilised questionnaires<sup>46, 50, 52-54</sup> and one collected data using an evaluation form, radar charts and focus groups<sup>49</sup>. Papers originated in the United Kingdom<sup>28, 46, 47, 49</sup>, United States of America<sup>50-55</sup>, Canada<sup>48</sup>, Puerto-Rico<sup>56</sup> and Nigeria<sup>57</sup>.

The sample within each of the papers spanned various specialities of medicine. Four of the retrieved papers used a sample of multiple specialities, or spoke of medicine generally<sup>28, 47, 48, 57</sup>, other papers focused upon one speciality; General Practice<sup>49</sup>, Paediatrics<sup>46</sup>, Internal Medicine<sup>50</sup>, Academic Medicine<sup>51, 55</sup>, Emergency Medicine<sup>53</sup>, Radiology<sup>54</sup>, hospitalists/primary care physicians<sup>52</sup> and the personal account focused upon the author, whom worked in Gastroenterology<sup>56</sup>.

Ten studies considered mentoring within a 'senior/junior' framework in which the mentor was more experienced than the mentee<sup>28, 47-50, 52, 54-57</sup>, one study described mentors as 'role models'<sup>51</sup>, one study described peer mentoring in which individuals were 'equal in age, experience and rank'<sup>46</sup> and one mentoring scheme used both 'vertical mentoring, peer mentoring and role modelling'<sup>53</sup>.

Of the research papers, three described mentoring experiences generally<sup>28, 47, 51</sup> whereas seven studies focused on one specific mentoring scheme<sup>46, 48-50, 52-54</sup>. Of those evaluating one mentoring scheme, four referred to one-to-one mentoring<sup>46, 50, 52, 54</sup>, one referred to group mentoring<sup>53</sup>, one study discussed both one-to-one mentoring and group mentoring<sup>49</sup> and one prospective study did not define this but participants suggested they would prefer one-to-one mentoring<sup>48</sup>. Three of the ten research papers included a sample of mentees only<sup>49, 52, 54</sup>. Others included mentors and mentees<sup>51</sup>, peer mentors and mentees<sup>53</sup>, mentees and non-mentees<sup>50</sup>, mentors, mentees and control participants<sup>46</sup>, mentors, mentees, scheme organisers and stakeholders<sup>28</sup> and prospective mentors or mentees<sup>47, 48</sup>. Sample sizes across all studies were relatively small due to the prevalence of qualitative or multiple method studies (Mean 74; SD 90.3; Range 12-329).

<b>Reference: Research papers</b>	<b>Aim</b>	<b>Medical speciality</b>	<b>Location</b>	<b>Method</b>
<b>Eisen, Sukhani, Brightwell, Stoneham &amp; Long (2014)</b>	To assess demand for peer mentoring among junior postgraduate trainees and to assess benefits for both peer mentees and mentors	Postgrad paediatric trainees	UK	Mixed methodology Questionnaire
<b>Harrison, Anderson, Laloe, Santillo, Lawton &amp; Wright (2014)</b>	To look at the perceptions of mentorship, the extent to which medics value mentorship and factors that contribute to its success	Medics	UK	Qualitative methodology Multi-site, semi-structured interviews
<b>Lockyer, Fidler, de Gara &amp; Keefe (2010)</b>	To examine the feasibility and focus of a mentoring scheme from the perspective of medical leaders and physicians new to Canada	Medics	Canada	Qualitative methodology Focus groups Interviews
<b>Mann, Ball &amp; Watson (2011)</b>	This pilot study aimed to use a prospective study design to look at the potential benefits of using a specified 'action learning' approach to mentoring	General Practitioners	UK	Mixed methodology Quantitative evaluation form and radar charts Qualitative focus groups and telephone interviews
<b>Ramanan, Taylor, Davis &amp; Phillips (2006)</b>	To describe mentoring relationships among internal medicine students and examine the relationship between mentoring and career preparation	Internal medicine residents	USA	Quantitative methodology Questionnaire
<b>Steven, Oxley &amp; Fleming (2008)</b>	To look at the perceived benefits of being involved in mentoring schemes and to explore the overlaps and relationships between the categories of perceived benefits	Medics	UK	Qualitative methodology Secondary data analysis Multi-site interviews
<b>Strong, De Castro, Sambuco, Stewart, Ubel, Griffith &amp; Jagsi (2013)</b>	To gain further understanding of work-life balance issues from clinician-researchers and their mentors	Academic medicine	USA	Qualitative methodology Semi-structured interviews
<b>Tietjen &amp; Griner (2013)</b>	To describe perceptions of a mentoring scheme after its first year	Hospitalists & primary-care physicians	USA	Quantitative methodology Questionnaire
<b>Welch, Jimenez, Walthall &amp; Allen (2012)</b>	To describe the content, perceived value and ongoing achievements of a mentoring scheme for women in Emergency Medicine	Women in Emergency medicine	USA	Mixed methodology Questionnaire
<b>Yamada, Slanetz &amp; Boiselle (2014)</b>	To evaluate radiology residents' experiences of a formal mentoring scheme, and to determine if mentees with self-selected mentors or assigned mentors had greater perceived benefits	Radiology residents	USA	Quantitative methodology Questionnaire

**Table 4: Details of non-research papers retrieved from the systematic search**

<b>Reference: Research papers</b>	<b>Aim</b>	<b>Medical speciality</b>	<b>Location</b>	<b>Method</b>
<b>Eisen, Sukhani, Brightwell, Stoneham &amp; Long (2014)</b>	To assess demand for peer mentoring among junior postgraduate trainees and to assess benefits for both peer mentees and mentors	Postgrad paediatric trainees	UK	Mixed methodology Questionnaire
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<b>Steven, Oxley &amp; Fleming (2008)</b>	To look at the perceived benefits of being involved in mentoring schemes and to explore the overlaps and relationships between the categories of perceived benefits	Medics	UK	Qualitative methodology Secondary data analysis Multi-site interviews
<b>Strong, De Castro, Sambuco, Stewart, Ubel, Griffith &amp; Jagsi (2013)</b>	To gain further understanding of work-life balance issues from clinician-researchers and their mentors	Academic medicine	USA	Qualitative methodology Semi-structured interviews
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<b>Welch, Jimenez, Walthall &amp; Allen (2012)</b>	To describe the content, perceived value and ongoing achievements of a mentoring scheme for women in Emergency Medicine	Women in Emergency medicine	USA	Mixed methodology Questionnaire
<b>Yamada, Slanetz &amp; Boiselle (2014)</b>	To evaluate radiology residents' experiences of a formal mentoring scheme, and to determine if mentees with self-selected mentors or assigned mentors had greater perceived benefits	Radiology residents	USA	Quantitative methodology Questionnaire

**Table**

<b>Reference: Research papers</b>	<b>Aim</b>	<b>Medical speciality</b>	<b>Location</b>	<b>Method</b>
<b>Eisen, Sukhani, Brightwell, Stoneham &amp; Long (2014)</b>	To assess demand for peer mentoring among junior postgraduate trainees and to assess benefits for both peer mentees and mentors	Postgrad paediatric trainees	UK	Mixed methodology Questionnaire
<b>Harrison, Anderson, Laloe, Santillo, Lawton &amp; Wright (2014)</b>	To look at the perceptions of mentorship, the extent to which medics value mentorship and factors that contribute to its success	Medics	UK	Qualitative methodology Multi-site, semi-structured interviews
<b>Lockyer, Fidler, de Gara &amp; Keefe (2010)</b>	To examine the feasibility and focus of a mentoring scheme from the perspective of medical leaders and physicians new to Canada	Medics	Canada	Qualitative methodology Focus groups Interviews
<b>Mann, Ball &amp; Watson (2011)</b>	This pilot study aimed to use a prospective study design to look at the potential benefits of using a specified 'action learning' approach to mentoring	General Practitioners	UK	Mixed methodology Quantitative evaluation form and radar charts Qualitative focus groups and telephone interviews
<b>Ramanan, Taylor, Davis &amp; Phillips (2006)</b>	To describe mentoring relationships among internal medicine students and examine the relationship between mentoring and career preparation	Internal medicine residents	USA	Quantitative methodology Questionnaire
<b>Steven, Oxley &amp; Fleming (2008)</b>	To look at the perceived benefits of being involved in mentoring schemes and to explore the overlaps and relationships between the categories of perceived benefits	Medics	UK	Qualitative methodology Secondary data analysis Multi-site interviews
<b>Strong, De Castro, Sambuco, Stewart, Ubel, Griffith &amp; Jagsi (2013)</b>	To gain further understanding of work-life balance issues from clinician-researchers and their mentors	Academic medicine	USA	Qualitative methodology Semi-structured interviews
<b>Tietjen &amp; Griner (2013)</b>	To describe perceptions of a mentoring scheme after its first year	Hospitalists & primary-care physicians	UAS	Quantitative methodology Questionnaire
<b>Welch, Jimenez, Walthall &amp; Allen (2012)</b>	To describe the content, perceived value and ongoing achievements of a mentoring scheme for women in Emergency Medicine	Women in Emergency medicine	USA	Mixed methodology Questionnaire
<b>Yamada, Slanetz &amp; Boiselle (2014)</b>	To evaluate radiology residents' experiences of a formal mentoring scheme, and to determine if mentees with self-selected mentors or assigned mentors had greater	Radiology residents	USA	Quantitative methodology Questionnaire



	perceived benefits			
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**Table 4: Details of non-research papers retrieved from the systematic search**

Reference	Type of paper	Medical speciality	Location	Purpose
<b>Banini (2013)</b>	Commentary	Academic medicine	United States of America	To highlight the work-life balance issues medics face and to comment on the study conducted by Strong, De Castro, Sambuco, Stewart, Ubel, Griffith & Jagsi (2013)
<b>Cruz-Correa (2014)</b>	Personal account	Gastroenterology	Puerto Rico	To describe the mentoring relationships that the author has experienced throughout their career
<b>Osaghae (2014)</b>	Discussion	Medics	Nigeria	To describe the mentoring of medics with the aim of informing medical practitioners about mentoring, and enabling medics to appreciate the importance of the mentoring process

## Thematic synthesis of findings

The following section is presented in consistency with the BITC Workwell model, in that the themes directly reflect the four components of the model; Better relationships, better physical and psychological health, better specialist support, and better work.

### *Better relationships*

The '*better relationships*' component of the BITC Workwell model<sup>2</sup> highlights the value of encouraging and enabling good communication, and ensuring effective relationships both inside and outside of the work environment). Improved relationships and communication provide 'social capital' which promotes employees' mental health, well-being, and engagement. Evidence from the reviewed literature suggests that mentoring enhances working relationships, increases networking opportunities and leads to the development of communication skills.

Participant feedback from a qualitative study exploring demand for mentoring, described mentoring as a mechanism to support personal and professional relationships, and enhance networking opportunities<sup>47</sup>. In another study, interviewees understood mentoring activities as having enhanced the professional practice and collegiality of both mentees and mentors, through facilitation of improved working relationships and teamwork<sup>46</sup>. The authors suggest this collegial approach fosters peer support which protects against feelings of isolation and adds to workplace satisfaction, an important component of well-being. Findings from other studies, based on participant feedback, also suggest that mentoring improved relationships with colleagues<sup>46, 49</sup>, with one study finding that '*the features participants liked best about the mentoring program related to the social networking, inclusiveness, and the supportive nature and camaraderie of the group*'<sup>53</sup>.

Relationships, both inside and outside of work, were perceived by participants as benefitting from communication skills acquired in mentor development<sup>28, 46</sup>. In the study conducted by Eisen, Sukhani<sup>46</sup>, peer mentors believed that their communication skills had improved, and they described learned skills such as the use of open questions and active listening. Peer mentors anticipated using newly developed communication skills in their personal lives as well as in work, for example, to support junior colleagues, with future consultations, and in their role as educational supervisor.

### *Better physical and psychological health*

The BITC Workwell model promotes the importance of a safe working environment, and healthy behaviours, to ensure '*better physical and psychological health*', which include stress, anxiety, intrinsic satisfaction, accomplishment, optimism, confidence, control, empowerment and safety.

Papers described engagement in mentoring as leading to accomplishment in the form of personal development. Personal development, referred to aspects of non-professional development, however, in some papers it was described generally with no definition given<sup>50, 54</sup>. Of the small number of studies stipulating specific aspects of personal development, mentoring was reported as leading to improved confidence<sup>46, 49, 52</sup>, increased energy levels<sup>49</sup>, and better stress management<sup>46, 52</sup>, as well as helping mentees 'grow' socially<sup>48</sup>, emotionally<sup>48, 57</sup> and intellectually<sup>57</sup>.

One study proposed three broad areas of benefit, and underlying processes that overlapped in mentoring; professional practice, personal well-being, and personal and professional development<sup>28</sup>. The same study suggested that personal well-being may be enhanced because mentors and mentees felt more confident, positive and reassured about their performance. The authors of the study

considered this was probably due to the additional skills and tools mentoring provided to individuals to deal with personal and professional issues, including problem solving and change management. Peer-mentors in the study conducted by Eisen, Sukhani <sup>46</sup> also felt that mentoring led to personal development due to enhanced listening skills and a structured problem solving approach. However, drawbacks were reported by Mann, Ball <sup>49</sup> who described adverse issues experienced by two mentees throughout a mentoring scheme; one participant withdrew from the scheme due to the emergence of mental health issues and one mentee remained in the scheme but found it difficult to engage and did not achieve positive outcomes. The mentor of the mentee with mental health problems also experienced adverse effects from the experience which affected their own health and well-being.

### ***Better specialist support***

The BITC Workwell model describes '*better specialist support*' as the early intervention, and proactive management, of employees' physical and psychological health. This involves helping teams to manage health issues at work, or facilitating employees' return to work through services such as occupational health, human resources, employee counselling, and training.

Within the papers reviewed, mentoring relationships were considered as a means of providing specialist support to employees in a confidential environment. However, resourcing issues were a concern for the sustainability of the training required to become a mentor.

Mentors were described as role models <sup>51, 53, 57</sup> and as being inspirational to mentees <sup>53, 56</sup>. Osaghae <sup>57</sup> considers mentoring as being able to '*assist doctors to gain emotional and intellectual growth to become independent practicing physicians*'<sup>57</sup>. All of the 10 research papers described mentoring schemes as an intervention aimed at providing support to mentees<sup>28, 46-54</sup>. Specifically, findings from interviews conducted by Harrison, Anderson <sup>47</sup> describe the protective nature of mentoring which can act as a '*safety net*' potentially reducing the likelihood of clinical errors. Registrars and newly appointed consultants felt that mentoring would help in managing the emotional burden of their new role, including their new managerial and leadership responsibilities<sup>47</sup>.

The mentoring relationship was viewed as a confidential environment for discussion. Qualitative findings described mentoring sessions as being '*a protected environment where the doctor could discuss their pressures in a non-judgemental space*'<sup>49</sup> and as '*an emotionally supportive and encouraging environment*'<sup>53</sup>. Participants in the study conducted by Eisen et al. felt that it was important that mentoring discussions were held in a confidential place where the mentee felt assured when discussing their own personal issues<sup>46</sup>. Eisen, Sukhani <sup>46</sup> also described the importance of formal training provided to mentors before being involved in mentoring support. Training was perceived as contributing to the scheme's success, enabling mentors to offer appropriate advice and support, and helping them limit conflict between the mentor and mentee. However, the authors also discussed the financial implications of this training influencing the sustainability of the mentoring scheme, suggesting training to be tailored to local need or budget, or using trained mentors in the scheme to train future mentors. Of the other five research papers describing, or evaluating one specific mentoring intervention, only two stated that mentors had undergone any formal or informal mentor training<sup>49, 52</sup>.

## Better work

This component of the BITC Workwell model focuses on supporting '*better work*' by ensuring the working environment is engaging and supportive and giving the employee a voice. Better work is further ensured by managerial styles and organisational culture which facilitate mutual trust and respect within the workplace. In addition, consideration of factors concerning job design, including the type of task completed and the variety of challenge, and workload also contribute to '*better work*'. This component of the BITC Workwell model is reflected throughout the three components previously discussed, as better relationships, better physical and psychological health and better specialist support all lead to '*working well*'.

The ways in which mentoring supported better work were evident throughout all of the 13 reviewed papers, including activities and functioning in their own professional role and role advancement, with some discussion of the benefits to the wider organisation. Participation in mentoring was reported as having a positive impact on: job satisfaction<sup>28</sup>; professional outlook<sup>46</sup>; educational support<sup>46, 54</sup>; increased energy levels and motivation<sup>49</sup>; as well as support when faced with professional disappointment or failure<sup>50</sup>. Furthermore, five papers proposed that mentoring improved clinical skills<sup>28, 46, 50, 54, 57</sup> with one paper highlighting how mentoring skills had supported a participant to '*take a more egalitarian approach to patients*' (Steven, *et al.*, 2008, pg. 554). Mentoring schemes also supported career progression and professional development, in the identification and discussion of career decisions<sup>46, 50, 52, 54</sup>, the identification and completion of career goals<sup>46, 52</sup> and also through the transference of expert knowledge from mentor to mentee<sup>56, 57</sup>.

Work-life balance was evidenced as being a beneficial outcome of mentoring schemes<sup>28, 46, 51, 53</sup> as mentoring was perceived to help mentees manage workload, including work-life balance<sup>52, 55</sup>. Banini<sup>55</sup> specifically articulated that mentors have a responsibility to '*take an active role in mentoring the younger generation*' in helping mentees achieve work-life balance<sup>55</sup>.

Although aspects of better work were primarily focussed on the individual's role, Welch *et al.* discussed the benefits of peer mentoring sessions in giving voice to employees to actively create change in the work environment across the wider organisation<sup>53</sup>. As part of peer mentoring sessions, participants addressed gender bias in the workplace which led to the development of a new family-leave policy as well as establishing dedicated on-site lactating facilities, and developing new collaborations between individuals<sup>53</sup>.

## Conclusions

Fundamentally, healthcare organisations require healthcare that is high quality, safe and compassionate<sup>58</sup>. To facilitate this, doctors' health and well-being must be considered as it impacts on staff retention, motivation, performance and patient safety. For this reason, NHS England has recently announced a plan to invest £5 million improving health and well-being<sup>59</sup>. The papers reviewed suggest that mentoring is seen to contribute to doctors' health and well-being by enhancing relationships, physical and psychological health, specialist support, and may lead to better work. Although presented as separate units within this review under headings of the BITC Workwell model<sup>2</sup>, all of these components interlink and impact on one another.

The findings suggest mentoring impacts on both professional and personal relationships due to increased collegiality, networking opportunities, and the enhancement of transferrable communication skills. In addition, relationships with key individuals and working in supportive teams, may impact upon stress by influencing levels of social support and role clarity<sup>60-62</sup>. Kalén, Ponzer<sup>34</sup> confirm mentoring relationships include the promotion of supportive cultures and

communities of practice, which may foster the development of social capital.<sup>1</sup> The findings from this review support the positive role mentoring may have in developing and sustaining social capital in the workplace.

Mental health issues, including stress, depression and anxiety, are frequent causes of sickness among employees of the NHS, with rates of suicidal ideation and completed suicides being relatively high amongst doctors<sup>6</sup>. This review suggests mentoring contributes to better physical and psychological health by enhancing personal development, confidence and stress management. However, one study highlighted adverse outcomes associated with unsuccessful mentoring which had repercussions for both mentee and mentor morale. Due to the nature of the inquiries within this review, it is not possible to illuminate the detail and complexity of the relationship between mentoring, and physical and psychological health. Further research is needed.

In the papers reviewed, mentoring is seen as a '*specialist support*' mechanism and as a lynchpin enabling '*better relationships*' and '*better physical and psychological health*', which when combined, prompts '*better work*'. The use of support mechanisms to enhance individual responses to workplace stresses and pressures is recognised as a mechanism to improve well-being<sup>6</sup> as is the organisation's responsibility to provide access to such support, including occupational health and specialist services<sup>2, 6</sup>. However, access to mentoring support is inconsistent across healthcare services, with variations including availability, access, preparation and training<sup>38, 64, 65</sup>. Of the seven research papers that discussed a mentoring scheme, only three stated mentors had undergone training<sup>46, 49, 52</sup>. Financial and resource implications on health service provision may impact upon the availability of mentorship, however, without adequate preparation for the mentor/mentee role the quality of the resulting support may be variable and unsustainable<sup>46, 49</sup>.

The final component of the BITC Workwell model is '*better work*'. All of the evidence reviewed referred to mentoring as supporting individuals to work '*better*' in some way including improvement of clinical skills, provision of career support, or improved work-life balance. The benefits of mentoring on work were due to the transference of knowledge, identifying and working through goals, as well as giving voice to employees. To enhance staff support and engagement, organisations are encouraged to embrace person-centred culture, many of the components of which are implicit to effective mentoring, as highlighted within this review<sup>66</sup>.

Utilising the BITC Workwell model as a theoretical framework for analysis to thematically synthesise the findings, a link emerged between mentoring and '*better relationships*', '*better physical and psychological health*', '*better specialist support*' and '*better work*'. This systematic narrative review has considered evidence generated from studies suggesting that mentoring, as a support mechanism, leads to improved relationships, improved physical and psychological health, and ultimately better work output and experiences. Work was directly articulated as being impacted by mentoring but was also implicitly affected by improving relationships and physical and psychological health. Additional research is needed to further consider the impact of mentoring support on doctors' health and well-being, as well as focusing on the impacts of mentoring on the mentor's health and well-being.

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<sup>1</sup> Social capital, is a process involving interactions and networks which promote shared values and sense of community (ONS, n.d.). It comprises of three attributes: trust, networks of relationships, and reciprocity and is specifically related to both job satisfaction and engagement with clinical improvements among health professionals (Stromgren, Ericksson, Bergman & Dellve, 2016).

## Part 2. Questionnaire Survey

### Aim

The questionnaire survey aimed to identify, describe and assess perceived links and relationships between engagement in mentoring activities and the health and well-being of those involved. A secondary aim was to contribute to a broader understanding of the potential impact and value of mentoring in the workplace. The use of the questionnaire allowed retrospective data to be gathered from doctors involved in mentoring activities for over two years.

### Questionnaire development

A mixed-method questionnaire was developed to allow retrospective data to be gathered from doctors involved in mentoring activities for over two years. The tool aimed to identify mentoring activities together with any perceptions and examples of relationships between mentoring and health and well-being. The tool drew on the Business in the community Workwell model<sup>2</sup> and included a wide range of questions generated from the systematic narrative review findings, the British Medical Association's cohort study<sup>12, 2</sup> and drew on the teams extensive experience in the field. To inform questionnaire development two semi-structured interviews were also undertaken with senior medical consultants with extensive experience of mentoring (> 10 years). The interviewees asked about mentoring experiences and the findings were fed into the questionnaire development.

SurveyMonkey® software (<http://surveymonkey.com>) was used as a platform for an online version of the questionnaire. Before being disseminated to participants, the questionnaire was pre-tested with a number of individuals (n=10), including team members and individuals unaffiliated with the project. Pre-testing was used to ensure that the online tool worked as intended without technical glitches, and that questions were clear, easy to understand, and free of spelling errors. The feedback from this pre-testing phase led to enhancements of the questionnaire, removing technical glitches, ensuring questions were clear, easy to understand, and free of spelling errors. The finalised questionnaire was then sent to participants. The questionnaire itself comprised of 29 questions over five sections:

- job role,
- mentor training,
- mentoring activities,
- issues brought to mentoring sessions and
- perceived impact of mentoring on health and well-being (**Figure 3**).

Questions were either fixed or open-text, and all open-ended questions were optional. The final version of the questionnaire distributed to participants included an initial information section, which described the purpose of the questionnaire, the reason as to why the individual had been asked to participate, confidentiality details, funder details, contact information for a member of the research team, and provided an estimated completion time of around 20 minutes. Written definitions of a mentor, mentoring, and health and well-being were included in this section.

**Figure 3: Questionnaire contents**

<b>Question</b>	<b>Response</b>
What is your current job/role?	<b>Open-text response</b>
How long have you been in this job/role?	<b>Open-text response</b>
Have you previously attended a formal mentor training course or development programme? (Generally a series of organised sessions)	<b>Fixed-response:</b> Yes / No
Who organised the mentor training course or development programme you attended? (E.g. Royal college, local NHS trust, professional association, local education and training board, Deanery)	<b>Open-text response</b>
Approximately when did you attend the course of development programme? (Year)	<b>Open-text response</b>
Were you taught any of the following models in your training? (Please tick all that apply)	<b>Fixed response:</b> The Skilled Helper model GROW-Goal, Current Reality, Options (or obstacles), Will (or way forward) OSKAR-Outcome, Scale, Know-how, Affirm & Action, Review CLEAR (Contracting, Listening, Exploring, Action, Review) No models were used in training Cannot remember/don't know <b>Open-text response:</b> Other (please specify)
Did you practise using any of the following models in your training? (Please tick all that apply)	<b>Fixed response:</b> The Skilled Helper model GROW-Goal, Current Reality, Options (or obstacles), Will (or way forward) OSKAR-Outcome, Scale, Know-how, Affirm & Action, Review CLEAR (Contracting, Listening, Exploring, Action, Review) No models were used in training Cannot remember/don't know <b>Open-text response:</b> Other (please specify)
In total, approximately how many people have you mentored since undertaking initial mentor training (in 1:1 sessions)?	<b>Open-text response</b>
Have you been involved in providing 1:1 mentoring sessions during the last 2 years?	<b>Fixed-text response:</b> Yes/ No
Approximately how many mentees do you currently mentor (with whom you have met 1:1 more than once during the past 2 years)?	<b>Open-text response</b>
Approximately how many 'one off' mentoring sessions have you undertaken during the past 2 years?	<b>Open-text response</b>

Are you currently a mentor for a formally organised mentoring 'scheme(s)'? (A formal 'scheme' may be organised by an NHS trust, Deanery, Royal college/other professional group/body. Such schemes organise mentoring by linking mentors and mentees and may help arrange mentoring meetings)	<b>Fixed-text response:</b> Yes / No
Please give more detail on who organises the scheme(s)	<b>Open-text response</b>
Please tell us where the scheme is located	<b>Fixed-text response:</b> West Yorkshire South Yorkshire and Bassetlaw North Yorkshire and Humber Merseyside Lancashire Greater Manchester Durham, Darlington and Tees Cumbria, Northumberland, Tyne and Wear Cheshire, Warrington and Wirral Arden, Herefordshire and Worcestershire Birmingham, Solihull and the Black Country Derbyshire and Nottinghamshire East Anglia Essex Hertfordshire and the South Midlands Leicestershire and Lincolnshire Shropshire and Staffordshire Bath, Gloucestershire, Swindon and Wiltshire Bristol, North Somerset, Somerset and South Gloucestershire Devon, Cornwall and Isles of Scilly Kent and Medway Surrey and Sussex Thames Valley Wessex Ayrshire and Arran Borders Dumfries and Galloway Fife Forth Valley Grampian



	<p>Greater Glasgow and Clyde  Highland  Lanarkshire  Lothian  Orkney  Shetland  Tayside  Western Isles  Greater London  Northern Ireland  Wales  <b>Open-text response:</b>  Other</p>
Are you currently involved in an informal mentoring relationship (i.e. organised by you and/or a colleague on an informal basis-without formal recognition or assistance)	<b>Fixed-text response:</b> Yes/No
Please tell us anything you can about the informal relationship (e.g. how and why it came about, who instigated it, how long it has been running etc).	<b>Open-text response</b>
Do you use your mentoring skills with colleagues other than as mentor and mentee?	<b>Fixed-text response:</b> Yes / No/ Not sure <b>Open-text response:</b> If yes, please tell us more
Which of the following issues have been raised or discussed at mentoring sessions?	<b>Fixed-text response:</b> Assessments/education Bullying/harassment Career choice Career development Coping with work after injury or illness Dealing with illness Dealing with injury Developing teams/services Engagement Managing a crisis Managing change Mental health issues, e.g. depression, substance abuse, addictions Morale Negative thoughts or suicidal ideation Personal relationships Physical health

	Relationships with colleagues Return to work after injury or illness Self-confidence Stress Taking an opportunity Thinking through clinical situations Work-life balance Workload <b>Open-text response:</b> Other
In relation to your current or previous mentees please describe* up to three memorable examples of different issues dealt with in mentoring sessions and, where possible, any outcomes (*without disclosing personal information about the mentee)	<b>Open-text response (x3 separate issues/questions)</b>
As a mentor, does being involved in mentoring influence/impact upon your...(please tick all that apply)	<b>Fixed-text response:</b> Workload Stress Satisfaction levels Working relationships Organisational/work culture Self-confidence Work-life balance Thinking through clinical situations Managing change Developing teams/services Personal relationships Morale Mental health Engagement e.g. in associations, extra activities, medical education Physical health Relationships with colleagues Dealing with injury Dealing with illness Career development Taking an opportunity Managing a crisis Assessments/education None of the above

	<b>Open-text response:</b> Other
Tell us about how being a mentor has impacted on you (positive impact as well as negative impact, surprising gains as well as expected impacts)	<b>Open-text response</b>
Do you currently have a mentor?	<b>Fixed-text response:</b> Yes/ No
Have you previously had a mentor?	<b>Fixed-text response:</b> Yes/ No
On the whole, do you think involvement in mentoring influences:	<b>Likert Scale:</b> Mentee health and well-being (1, very positively-5, very negatively) Mentor health and well-being (1, very positively-5, very negatively) <b>Open-text response:</b> Please explain your answer
To what extent do you think mentoring leads to a supportive environment?	<b>Likert scale:</b> For the mentee (1, not at all-5, very much) For the mentor (1, not at all-5, very much) <b>Open-text response:</b> Please explain your answer
Overall, to what extent do you think involvement in mentoring affects Drs' health and well-being?	<b>Likert Scale:</b> Mentee health and well-being (1, very positively-5, very negatively) Mentor health and well-being (1, very positively-5, very negatively) <b>Open-text response:</b> Please explain your answer
Have you been involved in providing mentoring sessions in the past by this has ended and/or been inactive for over 2 years?	<b>Fixed-text response:</b> Yes/ No

## Sample

All participants were over 18 years old and had capacity to give full informed consent. All participants were fully qualified doctors employed by the NHS. All participants had more than two years' experience of mentoring. The questionnaire was distributed to a total of 181 individuals via email. Emails were distributed to individuals through established networks (association of Anaesthetists of Great Britain and Ireland, London Deanery, Royal College of Physicians and Surgeons of Glasgow, Group of Anaesthetists in training). Participation was on an opt-in basis. On the occasion that emails were 'rejected' through system error an attempt to rectify unintended spellings errors, or to locate an alternative email address was made. Of the 181 individuals contacted, 57 participants responded (response rate: 31%). As participant information was confidential and all questionnaire responses were anonymous, it was not possible to distinguish which of these individuals chose to take part in this questionnaire from those contacted, or to understand the reasons as to why individuals chose to participate or not to participate, for example, it was unknown if all emails were read or even arrived at valid email addresses.

## Procedure

The questionnaire was distributed to individuals via email (Figure 4). The email provided details of what was required of the individual if they decided to participate, highlighted they had been contacted to participate, provided assurance of the confidentiality of responses, and provided the link to the questionnaire. An electronic link to the funder's website was also included in the email for further information. A copy of the participant information sheet was attached to the email.

Figure 4: Email distributed to participants

Dear Dr *NAME*,

We are undertaking research into potential links between Mentoring and Drs' health and well-being, this study is funded by the BMA.

<http://bma.org.uk/developing-your-career/portfolio-career/research-grants/celebrating-success/winners-2014/joan-dawkins>

Limited research and anecdotal evidence suggests that mentoring activities may offer a range of health and well-being benefits to doctors. This study will prospectively and retrospectively explore the relationship between doctors' health and well-being and engagement in mentoring.

We would like to ask you to complete a short questionnaire as part of this study

The questionnaire is designed to gather data regarding your mentoring activities and any possible links to health and well-being.

You have been contacted because you have been identified as someone who:

- has over 2 years' experience of mentoring activities and
- has undertaken some form of training to be a mentor.

If this is not the case can you kindly let me know by reply and we will remove you from our lists.

An information sheet is attached with further details; participation is voluntary and completion of the questionnaire constitutes informed consent.

All information will be rendered anonymous and your details will be kept confidential to the core research team (Alison Steven, Gemma Wilson, Val Larkin).

The questionnaire will take about 10-15 minutes to complete and can be accessed the questionnaire via the following link:

<https://www.surveymonkey.com/s/BMAmentor2015>

If you could kindly fill in the survey before DATE we would be most grateful.

Many thanks, Alison Steven.

The resulting themes were then presenting to the wider research team (JS,JW,NR) for scrutiny, challenge, confirmation and refinement. Descriptive statistics comprise of automatically generated statistics provided by SurveyMonkey®, as well as manually constructed statistics produced by the research team.

## Findings

The questionnaire findings are presented in four sections: Characteristics of mentors, characteristics of mentoring activities, issues raised, and perceptions of impact on health and well-being. As questions were not compulsory, some participant responses were not retrieved for each question, therefore, not all questions have a full response rate.

### *Characteristics of mentors*

Data retrieved from the questionnaire provided demographic information and contextualised the sample, based on their job role, mentor training and experiences of being a mentor (Table 3).

Although most of the questionnaire focused on the participants as being mentors, participants were also questioned regarding their own experiences of being a mentee. Eight respondents currently had their own mentor, although most did not (n=42). Around half of respondents had previously had their own mentor (n=26), whereas around half of respondents had never had a mentor (n=24).

Table 3: Demographic data of questionnaire respondents

<b>Job Role</b>	Consultant (n=45) Trainee (n=4) Retired (n=2) 'Other' (n=9)
<b>Length of time in practice</b>	21+ years (n=13) 16-20 years (n=14) 11-15 years (n=14) 6-10 years (n=9) less than 5 years (n=7)
<b>Specialties</b>  <b>In order to maintain anonymity these have been grouped</b>	Anaesthesia/ Surgery (n=15) Medical specialties n=11 Obstetrics/gynaecology/ Paediatrics (n=6) Specialties working with longer term patient groups (n=6) Biomedical specialties (n=5) No information given (n=13)
<b>Location of training undertaken</b>	Deanery training (n=39) Hospital/trust (n=7) Royal College (n=5) Educational institution (n=3) 'other' (n=3)
<b>Training completed</b>	16-20 years ago (n=7) 11-15 years ago (n=15) 6-10 years ago (n=21) 2-5 years ago (n=13)

Location of training scheme	In order to maintain anonymity we have not included this information
<b>Mentoring models taught during training</b>	The Skilled Helper model (n=44) GROW (n=10) OSKAR (n=2) CLEAR (n=7) Cannot remember (n=8) More than one model (n=14) Other (n=2)
<b>Mentoring models practised</b>	The Skilled Helper model (n=41) GROW (n=11) OSKAR (n=2) CLEAR (n=7) Cannot remember (n=8) More than one model (n=13) Other (n=1)

### *Characteristics of mentoring activities*

The questionnaire captured details of the number of mentees participants had mentored since training, as well as how many mentees they were mentoring at the time of questionnaire completion (Table 4).

Table 4: Number of mentees

<b>Number of mentees since training</b>	0 mentees (n= 2) 1-5 mentees (n=18) 6-10 mentees (n=12) 11-15 mentees (n=6) 16-20 mentees (n=5) 21+ mentees (n=9) Undisclosed/unanswered (n=5)
<b>Number of mentees currently</b>	0 mentees (n=9) 1 mentee (n=13) 2 mentees (n=11) 3 mentees (n=5) 4 mentees (n=2) 5+ mentees (n=1) Undisclosed/unanswered (n=15)

Since training, participants had various mentoring experiences. Most respondents indicated that they had been involved in providing 1:1 mentoring sessions over the last two years (n=42) whereas 10 respondents had not participated in 1:1 mentoring during this time. Eight participants reported having been involved in mentoring, but had been inactive for at least two years. Most respondents indicated currently being a mentor in a formally organised scheme (n=31) and 11 of the participants reported not currently being involved in a formal mentoring scheme.

Mentees were broadly described as being other colleagues (n=11), however, some respondents specified that mentees were typically trainees (n=8), junior colleagues (n=5) or those new in the consultant role (n=3). The way in which mentoring was initiated also differed as some participants initiated mentoring themselves, as the mentor (n=3), but most reported mentoring as being initiated by the mentee (n=13).

Respondents reported the frequency of 'one-off' mentoring sessions that they had participated in over the last two years (Table 5).

Table 5: Number of 'one-off' mentoring sessions

<b>Number of 'one-off' mentees (over last 2 years)</b>	0 mentees (n=5) 1-5 mentees (n=23) 6-10 mentees (n=5) 11-15 mentees (n=3) 16-20 mentees (n=1) 21+ mentees (n=1) Undisclosed/unanswered (n=17)
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Twenty-eight respondents reported being involved in an informal mentoring relationship since completing training, however, caution must be taken as definitions of 'formal' mentoring and 'informal' mentoring were not given to participants. This issue was highlighted by one participant who felt that *'the formal/informal boundary is rather grey (P029)'*. From the qualitative comments, it was apparent that participants understood 'informal' mentoring as being integrated into daily practice (n=7) and was part of their *'everyday job (P012)'*. One participant felt that the informal mentoring processes may be popular as there remains a reluctance from those who seek help to engage with formal processes.

*"[Colleagues] do not want to go through official channels because they fear that managers will find out and it will be seen as weakness"*  
[P036]

Mentoring skills were reported as being used with trainees/supervisees (11), appraiser/appraisal related (5), doctors in difficulty (2), but also with patients and their families (3). Almost all respondents reported using their mentoring skills outside of mentoring sessions, with other colleagues (n=46), three respondents believed they did not use their mentoring skills with other colleagues and one individual was unsure. Participants described using these skills *'all the time (P006; P014; P034; P038)'* outside of mentoring sessions (n=13). Of those that described which transferable skills they used outside of mentoring sessions, they stated using active and empathetic listening skills (n=6), questioning skills (n=2), facilitating skills (n=1) or described *'general'* skills used (n=4). It was iterated that skills were used to improve: communication and professional interactions with colleagues (n=5), team working (n=3) including *'in clinical work, with patients and families and working within a team (P026)'*, problem solving and decision-making (n=2), conflict management (n=3) and to generally support others (n=1).

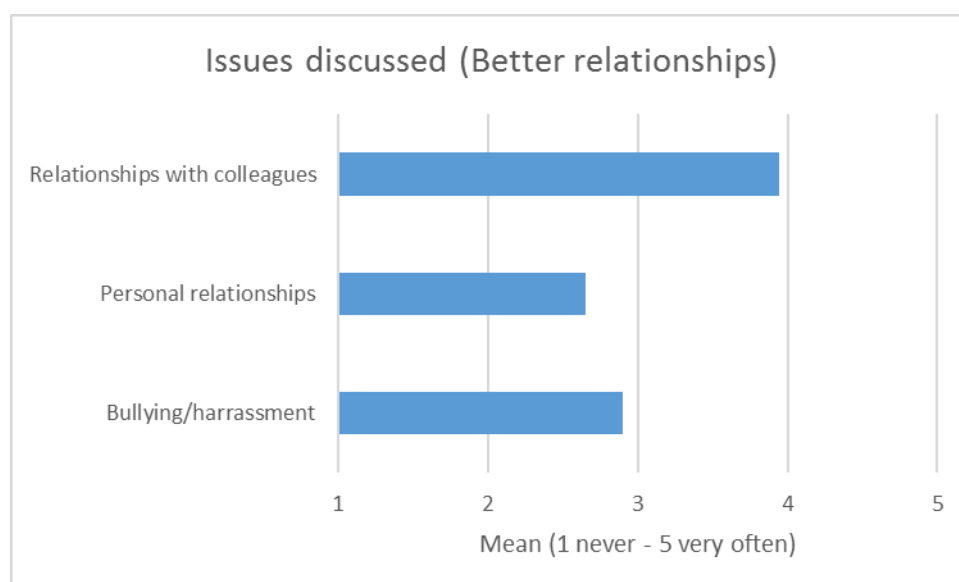
### Issues discussed

Participants were asked to indicate which issues were discussed by mentees, from a prescriptive list as part of the questionnaire. Participants were also asked to describe up to three examples of issues brought to mentoring sessions by mentees. Consistent with the systematic narrative review findings, data retrieved from the issues raised will be reported in this section using three of the four components of the BITC Workwell model; better relationships, better physical and psychological health, and better work.

### Better relationships

Participants indicated how often mentees discussed relationships with others as part of mentoring sessions on a scale ranging from 1 (never) to 5 (very often; Figure 5).

Figure 5: Issues brought to mentoring sessions regarding better relationships (mean) on a scale from 1 (never) to 5 (very often)



Participants reported mentees most often discussing relationships with colleagues (3.94), followed by bullying/harassment (2.90) and personal relationships (2.65). Within the examples described, there were many in which mentoring focused on their relationship with other colleagues.

*"relationships in team" [P012]*

*"Poorly functioning teams and workplace relationships" [P016]*

*"conflict with other staff members" [P022]*

*"Relationships with colleagues leading to departmental breakdown"*  
[P034]



In one case, the mentee sought mentorship as the trainee “*felt that everyone was against them* (P012)”. Through mentorship, this individual began to see their situation in a different light.

*“Initially it appeared as though they had a bad placement – it later became evident the trainees perceptions were off and the problem was really around the trainee not the placement – the trainee gradually started to see this” [P012]*

Issues of “*bullying* (P016; P040; P041; P044)” were also discussed. Mentors described various examples of collegial issues brought to mentoring sessions, and how they were dealt with.

### **Better physical and psychological health**

Participants indicated how often mentees discussed various aspects of their physical and psychological health on a scale ranging from 1 (never) to 5 (very often; Figure 6).

Figure 6: Issues brought to mentoring sessions regarding better physical and psychological health (mean) on a scale from 1 (never) to 5 (very often)



Participants reported mentees mostly discussing issues related to stress (3.84), morale (3.76), managing a crisis (3.54), and least discussing issues related to mental health issues (2.3), dealing with an injury (1.98) and negative thoughts or suicidal ideation (1.7). Despite participants reporting low incidence of discussion around ‘*dealing with an injury*’, some free-text examples specifically reference physical illness, or mental health issues, as concerns discussed in mentoring.

*“Managing a chronic condition – physical and mental health – person left the specialty and left medicine later” [P003]*

*“Managing a doctor who had returned to work following a prolonged absence due to ill health” [P012]*

*“Coping with illness” [P014]*

*“Illness or disability impacting on progression” [P018]*

*“Return after depression” [P022]*

*“Trainee returned to work after serious injury – required help to talk through career choices as previous specialty was no longer possible” [P025]*

*“Post-burnout. Difficult recovery. Ongoing” [P031]*

Mentors felt that mentees discussed various feelings of self-deficit, such as feelings of *“guilt and inadequacy (P032)”* and being *“undervalued (P031)”*. Lack of self-confidence also often featured in the examples. In some cases, the mentees’ low self-confidence specifically coincided with a negative event, such as a period of absence or a critical incident.

*“Consultant with self-belief and confidence shattered after patient’s death” [P013]*

*“Managing a doctor who had returned to work following a prolonged absence due to ill health – dealing with confidence issues” [P012]*

*“Returning to work after extended maternity leave and loss of confidence in dealing with clinical situations especially emergencies” [P041]*

*“Due to personal health related concerns, one of our trainees had lost self esteem, confidence and trust in others.*

*“Confidence issues following return to work following severe illness” [P029]*

*“Return after long-term sick leave. Lack of confidence” [P031]*

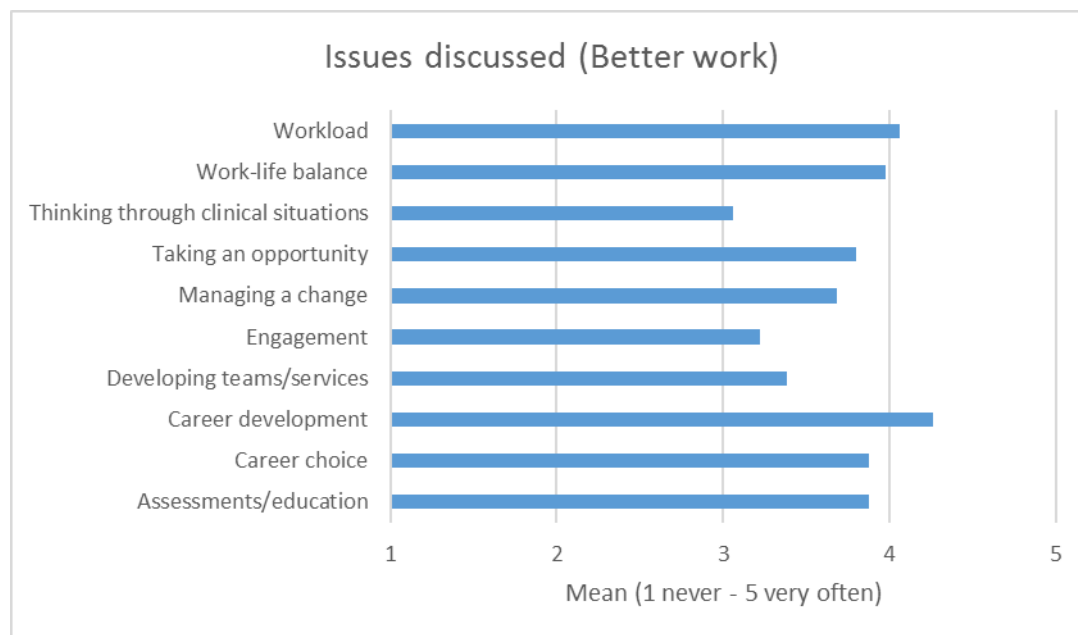
*“Returning to work after extended maternity leave and loss of confidence in dealing with clinical situations especially emergencies” [P041]*

Some personal issues were also brought forward to mentoring sessions, including the *“decision about remaining in the NHS or taking the option of uprooting family and working abroad (P021)”*, the *“terminal illness in a life partner (P029)”* and *“partner issues (P050)”*.

### Better work

The vast majority of issues discussed in mentoring sessions were directly work-related sessions on a scale ranging from 1 (never) to 5 (very often; Figure 7).

Figure 7: Issues brought to mentoring sessions regarding better work (mean) on a scale from 1 (never) to 5 (very often)



Mentors reported career development (4.26), workload (4.06) and work-life balance (3.98) as being most often discussed work-related issues in mentoring sessions, and reported developing teams/services (3.38), engagement (3.22) and thinking through clinical situations (3.06) as being the topics least often discussed.

Career guidance was discussed in mentoring sessions in varying ways, including general career choice (P006; P007; P010; P012; P020; P027; P029; P047; P054; P057), career development and promotion (P014; P015; P016; P019; P048; P053; P055), academic research opportunities (P007; P025), and in some cases, individuals discussed practice development (P010; P026; P040; P042). Progression in training and assessment was also discussed (P001; P013; P034; P045; P050).

Mentors gave specific examples of “workload (P014; P030; P053)”, including “workload related stress (P018)” and “managing work load - review of work load, thinking about how it could be managed differently (P002)”. “Work-life balance (P003; P021; P030; P034; P053; P057)” issues were also discussed. One participant provided an in-depth, complex account of long-term mentoring experience burn out.

*“Much of the mentoring was about containing ambition into ‘bite-sized’ chunks and avoiding taking on too much at once. The mentee feedback that the mentoring had been pivotal in enabling a step-wise approach to developing the successful new service and the*

*organisational strategy. Ten years later, this individual 'burned out' and took time off work with depression. We met 3 times as the mentee was returning to work, this time with a new understanding of work-life balance. We met 3 times as the mentee was returning to work, this time with a new understanding of work-life balance. The mentee was able to develop a plan to work 4 days and protect personal and family time on returning to work, and remains well and effective 2 years later" [P040]*

Mentees often discussed individual deficits as part of the mentoring sessions, specifically skill deficits, such as poor “*ability* (P007; P045)” and “*clinical performance* (P055)”. Finally, mentors described examples of misconduct that led to involvement in mentoring (P001; P006; P026; P034; P045; P050).

### ***Perceptions of impact on health and well-being***

Participants were asked to report how they perceived mentoring as impacting on the health and well-being of mentors, mentees and doctors, as well as being asked the extent to which mentoring leads to a supportive environment. Consistent with findings from the systematic narrative review, data focusing on issues related to health and well-being collected using the questionnaire is also reported in this section using the structure of the BITC Workwell model; better specialist support, better relationships, better physical and psychological health, and better work.

### ***Better specialist support***

Participants reported their own perceptions of how mentoring (as a form of specialist support) influences the health and well-being of mentors and mentees (Figure 8) and the extent to which they believed mentoring influences the health and well-being of doctors (Figure 9**Error! Reference source not found.**). Both were measured on scales ranging from 1 (very negatively) to 5 (very positively).

Figure 8: Perceived influences of being involved in mentoring for mentees and mentors (mean) on a scale from 1 (very negatively) to 5 (very positively)

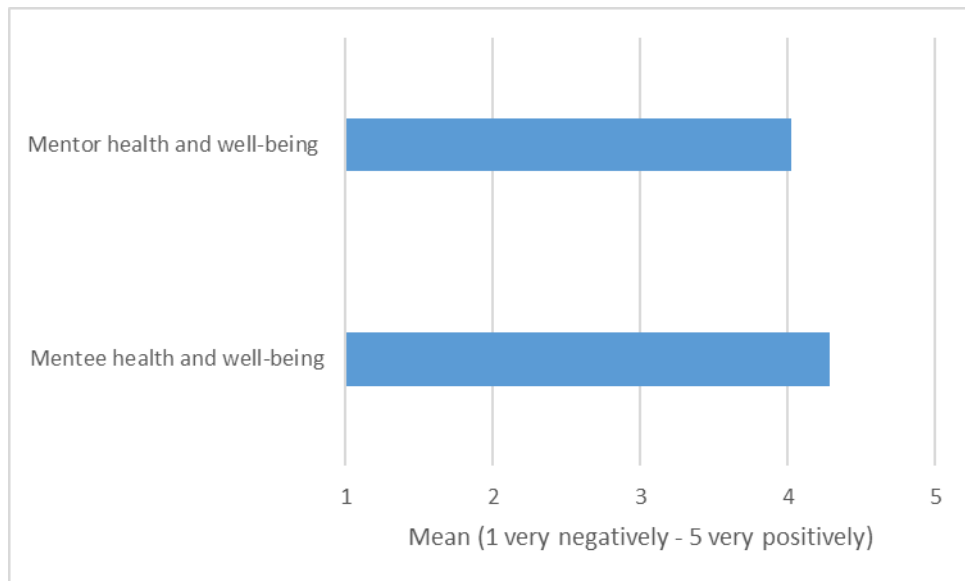
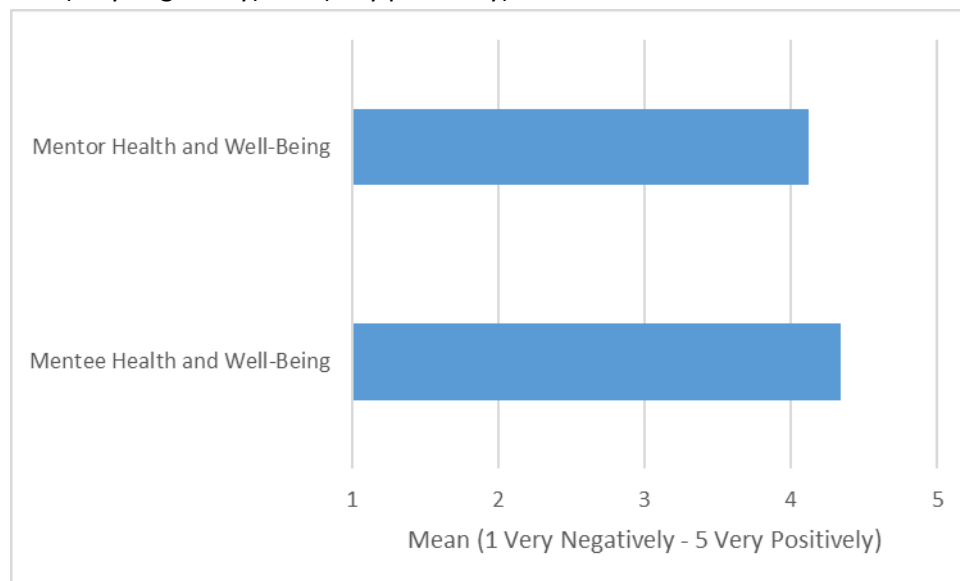


Figure 9: Extent to which involvement in mentoring affects doctors' health and well-being (mean) on a scale from 1 (very negatively) to 5 (very positively)



In both instances, respondents described a slightly more positive outcome for mentees (mean 4.28; 4.34, respectively) than mentors (mean 4.02; 4.12, respectively). When describing the ways in which they believed mentoring influences the health and well-being of mentors and mentees, participants reported the importance of “*trust* (P032; P041)”, being “*listened to non-judgementally and respected* (P029)” and being “*confidential* (P052)”. One participant specifically described mentoring sessions as allowing mentees to “*disgorge things instead of letting things eat them up inside* (P052)”. However, some participants felt that a condition to the extent in which mentoring can influence the health and well-being of both mentors and mentees is the mentee’s understanding of it.

*“Beneficial if the mentee understands the purpose of the relationship and wants it” [P011]*

*“I think mentoring should be open to all doctors-the shame is that most do not understand it-to have a good outcome from mentoring you have to engage with it and to understand what mentoring is0you almost need to have done the course to get it” [P012]*

*“Both need to understand the possibilities and limitations of mentoring” [P013]*

Participants also described the importance of the supportive environment, away from everyday working.

*“the opportunity to talk in a safe environment and to learn from each other” [P021]*

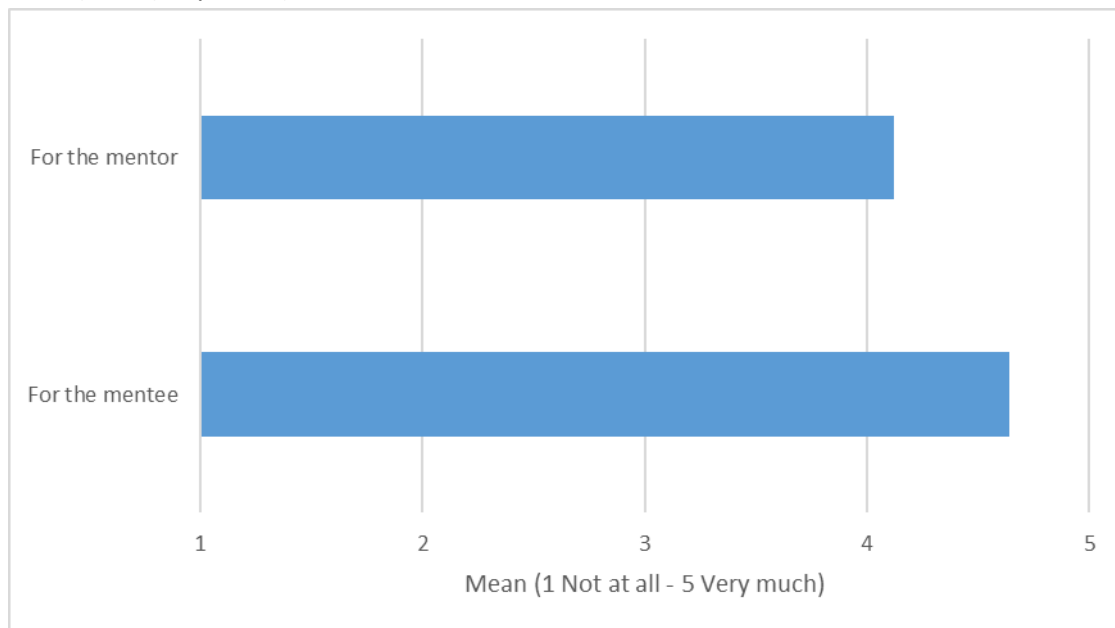
*“Time out from busy pressured work for both mentor and mentees, and the thinking time it brings” [P026]*

*“Mentoring is an opportunity to stand back and gain perspective on issues, challenges and problems” [P040]*

*“On both sides it can help get your ideas in order to allow you to see the wood from the trees” [P045]*

The supportive environment was further examined as respondents were specifically asked to what extent they believed mentoring led to a supportive environment for both the mentor and mentee, on a scale ranging from 1 (not at all) to 5 (very much; Figure 10).

Figure 10: Extent to which mentoring leads to a supportive environment (mean) on a scale from 1 (not at all) to 5 (very much)



Mentoring was also thought to create a supportive environment for both mentee (4.64) and mentor (4.12), again, with the environment being perceived as slightly more supportive for the mentee. When describing this supportive environment further, mentors described it as *“protected time (P001)”* that is *“non-competitive (P032)”*, and a *“caring environment where people trust each other and can be open and honest (P029)”*.

One limiting factor that was perceived as affecting the presence, and influence, of mentoring schemes is the organisational support received.

*“By offering protected time and maintaining confidentiality throughout the supportive environment is nurtured for both mentor and mentee” [P001]*

*“Does depend on organisational support” [P010]*

*“I think that because time has been made for mentoring in what for most is a very busy working day, the whole organisation/culture starts to understand that good human interaction is a key component of safe healthcare” [P013]*

*“The relationship is supportive while it lasts, but, in my organisation, it seems very difficult to achieve dissemination of a ‘coaching-style culture’ [P015]*

*“Being allowed time in my job-plan for mentoring would make me feel that the organisation values this contribution” [P040]*

*“Lack of understanding leads to a lack of support for the process by colleagues” [P045]*

*“Depends on the value the employer places on it” [P055]*

An unsupportive organisation is viewed as negatively affecting mentor activities for both the mentor and mentee. Two participants also specifically described the positive influences of a supportive organisation.

*“I think because time has been made for mentoring in which for most is a very busy working day, the whole organisation/culture starts to understand that good human interaction is a key component of safe health care” [P013]*

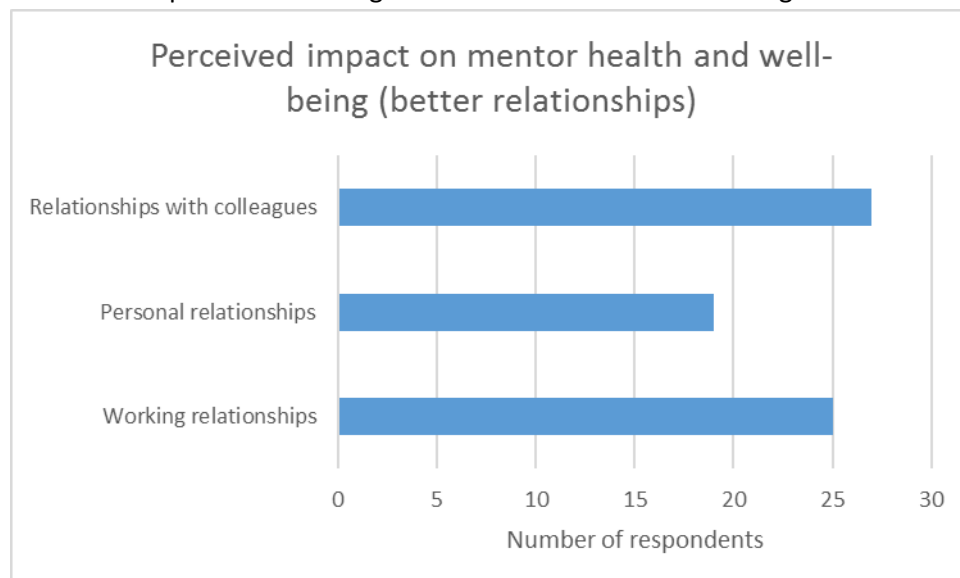
*“the mentee feels valued by the organisation in most cases” [P021]*

Respondents also felt that the implementation of peer support groups could enhance the supportive environment for themselves, as mentors. One participant suggested the role of a *“peer group and regular refresher/support events (P026)”* to support mentors, whereas another participant believed that *“it would lead to a supportive environment for the mentor if there was a mentoring support network where mentors met regularly and the mentor was helping those in their own department (P057)”*.

### **Better relationships**

In terms of better relationships, participants reported mentoring as mostly influencing their relationship with colleagues (n=27), followed by working relationships (n=25) and finally personal relationships (n=19; Figure 11).

Figure 11: Perceived impact of mentoring on mentors health and well-being





When asked to provide further information, participants described how they perceived mentoring as influencing better relationships and communication with others.

*“Takes time but positive impact of seeing people benefit from the relationship” [P011]*

*“Better relationships with work colleagues and friends” [P015]*

*“Better relationships with newer consultants in the trust” [P030]*

*“I have enjoyed the challenge of working with a variety of people from diverse clinical backgrounds; I have enjoyed the insights into other teams and departments” [P040]*

*“Engagement with colleagues in a different way” [P048]*

*“It makes me a lot more tolerant about others” [P052]*

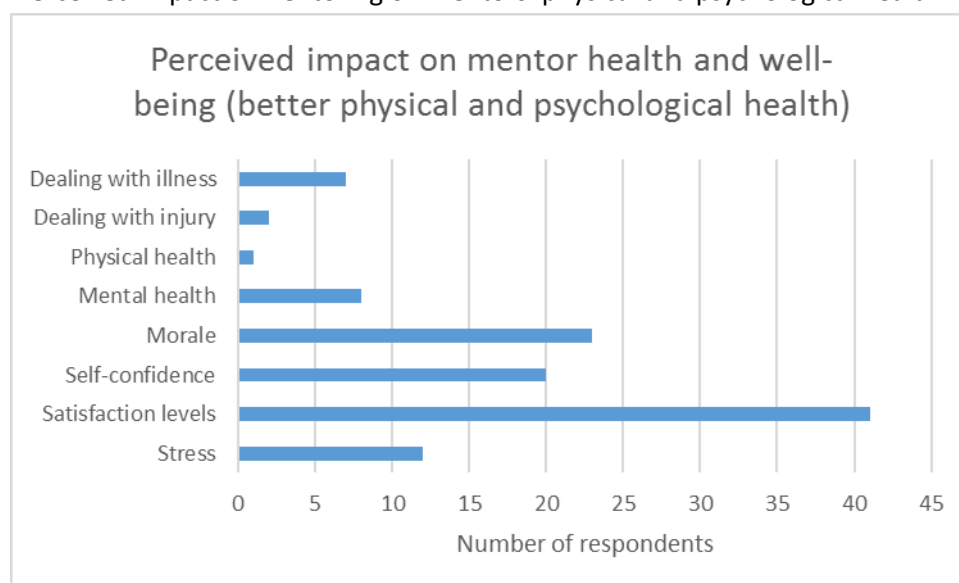
*“I think it supports [...] the ability to interact positively with colleagues” [P055]*

In addition to improving these relationships, participants described the benefit of being able to help others. Participants described mentoring as allowing them to *“make decisions and sort through issues (P002)”*, *“share others’ difficulties and hopefully help them find a solution (P003)”*, as well as having a *“real sense of privilege in being able to help these very able people at a key point in their lives (P026)”*.

### **Better physical and psychological health**

Participants described mentoring activities as having an impact of various aspects of physical and psychological health (Figure 12).

Figure 12: Perceived impact of mentoring on mentors’ physical and psychological health



Mentors reported mentoring activities as most impacting their 'satisfaction levels' (n=41) and 'morale' (n=23), and least influencing physical health, specifically, 'dealing with injury' (n=2) and their 'physical health' (n=1). In providing further information, it was evident that participants derived satisfaction from mentoring, and most participants described some personal rewards gained from being a mentor, with one respondent specifically reflecting on mentoring as giving them *"a sense of legacy (P006)"*. One particularly positive quote relayed mentoring as being *"the closest we can get to a professional 'elixir of life' (P044)"*. Other participants described involvement in mentoring as being satisfying, and improving confidence and morale.

*"Good for morale and self-confidence" [P007]*

*"The fact that I am sought out by colleagues by 'word of mouth' is very satisfying" (P040)*

*"I see it as part of my role and derive great satisfaction in being able to use my mentoring to help others" (P044)*

Participants enjoyed the opportunity to help other colleagues.

*"Good to be able to support other colleagues" [P002]*

*"Good to share others' difficulties" [P003]*

*"Helping seeing someone reach a decision and manage change is very satisfying" [P012]*

*"Scratch beneath the surface and people are struggling, unfulfilled and have often lost long-term purpose. A good mentor can unstick this stuckness" [P006]*

However, when helping others, one problem that arose was the *"lack of follow-up once mentoring finished (P003)"* which one participant described as having negative impact on themselves as a mentor. It is evident that learned mentoring skills enabled the individuals to self-reflect on their own behaviours.

*"It has given me some insights into my own past mini-crises" [P006]*

*"I think I have learnt to recognise my own poor behaviours" [P013]*

*"Greater self-awareness and self-management" [P015]*

Some participants reported mentoring as being a *"two-way process (P050)"* and mutually beneficial for both the mentor and mentee.

*"Both parties benefit" [P010]*

*"I think it can reduce stress for all concerned" [P012]*

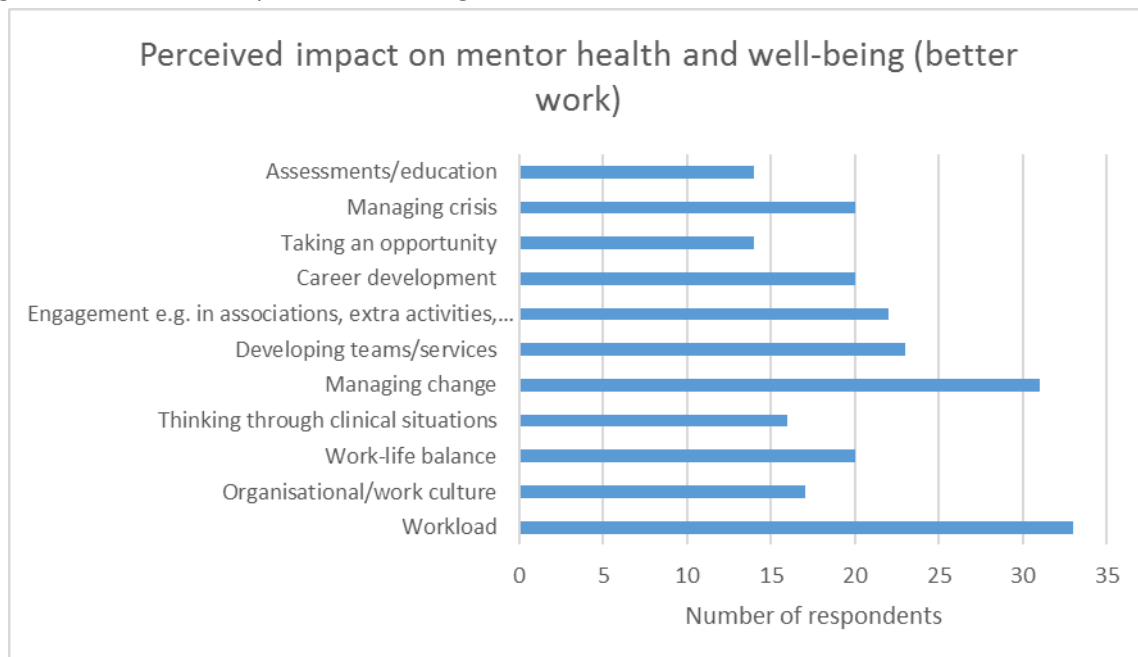
*"It is always mutually beneficial" [P030]*

Whilst the majority of responses reported positive influence on psychological well-being, some participants described mentoring as being *"stressful (P040)"*, *"mentally draining (P036)"*, *"energy consuming (P031; P048; P057)"*, *"exhausting (P036)"*, *"uncomfortable (P001)"* and *"frustrating (P032; P055)"*. One participant described mentoring as leading to *"sleepless nights when the process runs into difficulties (P045)"*, another felt that it was only beneficial for the mentee themselves as *"[the mentee] gets benefit, [the mentor] gets hassle (P023)"* and one found it difficult as *"you never get credit for it (P036)"*.

### Better work

Participants reported mentoring activities as affecting various work-related issues (Figure 13). When discussing aspects of mentoring impacting work, participants mostly reported impact on workload (n=33) and managing change (n=31), and least reported mentoring as having an impact on their assessments and education (n=14) or the ability to take opportunities (n=14).

Figure 13: Perceived impact of mentoring on mentors' better work



Participants described the added time pressures associated with involvement in mentoring activities.

*"Time is the only big resource that is always at a premium" [P027]*

*"Sometimes it is time consuming and difficult to meet due to busy work commitments etc" [P007]*

*"Problem is time. When I most need mentoring I don't have time to seek out and get" [P016]*

*"The time commitment in a busy NHS post with increasing clinical workload influenced [my] choice to opt out at this time" [P021]*

*"Takes time which is not recognised in my job plan" [P029]*

*"Negative – time" [P033]*

*"While being a mentor increases workload and makes me late home to my own family, with it comes the compensation of having done something worthwhile and it excites me to do further training which will improve my capacity as a post-graduate trainer" [P052]*

*"Time for mentoring is a major issue" [P053]*

*"I would have liked to do more mentoring but basically haven't taken any on for years (haven't been asked) because I don't have the time and emotional energy to mentor due to my own workload and work pressure/stress" [P057]*

However, despite the negative impact of added time pressures, the mentors also reported increased health and well-being as mentoring positively influenced their own work.

*'Self-revealing [...] better work-life balance' [P010]*

*'I have learned how to be a much more effective listener in all areas' [P026]*

*'Given me skills in dealing with situations' [P038]*

*'Opens up a whole new way of thinking' [P016]*

*'Helps me put my own work issues in perspective, helps me to see new ways of managing my own work' [P057]*

*'For the mentor, it is nice to develop new skills, a new sense of efficacy and something that-for once-you get better at as you get older' [P006]*

Participants reported that being a mentor provided new skills and new ways of thinking about their own work.

The questionnaire has indicated an overall positive view of the impact of mentoring on both mentors and mentees health and wellbeing across a range of areas.

## Part 3: A prospective case study tracking the impact and influence of mentor training and mentoring activities on health and well-being

### Aim

The case study element aimed to examine any links between mentoring activities and health and well-being by tracking trained mentors over time thus developing a detailed 'real time' picture of their mentoring activities.

### Sample

A purposive sampling strategy was used to recruit doctors who had undertaken mentor training *within* two years of recruitment to the study. Participants were identified using distribution lists of people who had attended various mentor training groups, nationwide, during the past two years. Participants were included if: they were 18+ years old, were a qualified doctor, had undertaken mentor training and/or been involved in mentoring activities for less than two years, had capacity to give full informed consent, and worked in the NHS.

The reason for focusing on doctors trained within the previous two years was to engage participants who were still 'conscious' of their mentoring skills and activities as previous research<sup>28</sup> has indicated mentoring skills can become embedded into everyday practice.

A total of 13 participants (10 male; 3 female) located across the UK, participated. Participants were from a range of specialties including surgery, anaesthetics, general practice, and general medicine. Nine participants completed all four interviews, two participants dropped out of the study after completing two interviews with no reason given for drop out, and two participants could not complete one of the interviews, due to ill health (see table Table 6) . Interviews took place over a 20 month period from 2015-2017. No further detail regarding the participants characteristics or identity will be given in order to maintain anonymity.

Table 6 : Interview numbers

Interview sequence	A : 1st Interviews	B : 2nd Interviews	C : 3rd Interviews	D : 4th Interviews	Total number of interviews
Participants	13	13	8	9	43

### Materials

The findings from the questionnaire element of the study informed the development of an interview preparation document (IPD) and the interview schedule. The IPD was developed for use in the first interview only and was given to participants prior to the first interview (Table 7) it asked individuals to record the time of mentor training, the model(s) followed in training, current number of mentees, number of mentees since completing training and if they currently have a mentee. The purpose of this document was to initiate and prompt thinking about their mentoring experiences, and to inform the first interview schedule.

Table 7 Interview preparation document

Approximately when did you attend a formal mentor training course/development programme?
Were you taught any of the following models in your training? (Please tick all that apply) <ul style="list-style-type: none"> <li>• The Skilled Helper</li> <li>• GROW (Goal, Current Reality, Options (or Obstacles), Will (or Way forward)</li> <li>• OSKAR (Outcome, Scale, Know-how, Affirm &amp; Action, Review)</li> <li>• CLEAR (Contracting, Listening, Exploring, Action, Review)</li> <li>• No models were used in the training</li> <li>• Cannot remember/don't know</li> <li>• Other (please specify)</li> </ul>
Approximately how many mentees do you currently mentor?
Approximately how many mentees have mentored since completing mentor training?
Do you currently have a mentor? <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>

Once the interview preparation document was complete, the interview proper began following a semi-structured schedule (Table 8). The interview schedule was developed using the framework of the BITC Workwell model<sup>2</sup>, the findings from part one of this project, as well as the literature pertaining to well-being. However, in accordance with principles of semi-structured qualitative interviews, the interview guide was not followed in a prescriptive manner as each mentors narrative was unique, which in turn evoked a particular follow up question <sup>67</sup>. Thus, issues identified in the IPD were explored in greater depth with the participants enabling a more detailed illumination of the participants, thoughts and mentoring activities. Researchers also allowed participants to raise other issues they felt to be of importance so as not to deny the opportunity for new insight development.

Table 8 Semi structured interview guide

<b>Training</b> <ul style="list-style-type: none"> <li>• Discuss information in interview preparation document.</li> <li>• How useful did you find the training?</li> <li>• Did you practice skills in training?</li> <li>• Why did you decide to attend mentor training?</li> </ul>
<b>Mentors</b> <ul style="list-style-type: none"> <li>• Discuss information in interview preparation document.</li> <li>• Have you had a mentor yourself in the past?</li> <li>• Did this have an impact on you?</li> </ul>
<b>Mentees</b> <ul style="list-style-type: none"> <li>• Discuss information in interview preparation document.</li> <li>• How did you become linked to your mentee(s)?</li> <li>• Have you mentored anyone informally?</li> <li>• How many times did you/do you meet?</li> <li>• What type of issues has been brought to your mentoring sessions? (<i>probing for detail</i>)</li> </ul>

<ul style="list-style-type: none"> <li>• Do you mind sharing these issues? (<i>probing for detail and concrete examples</i>)</li> <li>• Do you think the mentoring had an impact on the mentee?</li> <li>• Do you think the mentoring had an impact on you, as the mentor?</li> </ul>
<b>Other</b> <ul style="list-style-type: none"> <li>• How have you found being a mentor/mentee?</li> <li>• What has been the most valuable thing about being a mentee/mentor?</li> <li>• Do you think you use your skills in your work, or otherwise?</li> </ul>

As is established practice in qualitative research, interview schedules were tailored according to the sample and issues arising<sup>67</sup>, and therefore were revised throughout each subsequent interview, as the individual was asked about issues in which they had discussed in previous interviews, therefore each interview was personal, and reflected previous discussion.

## Procedure

An introductory email was sent to individuals that had participated in mentor training less than two years prior to this recruitment email being distributed (Figure X).

**Figure X: Recruitment email send to potential participants**

Dear NAME,

We are undertaking research into potential links between Mentoring activities and Drs' health and well-being, this study is funded by the BMA.

<http://bma.org.uk/developing-your-career/portfolio-career/research-grants/celebrating-success/winners-2014/joan-dawkins>

Limited research and anecdotal evidence suggests that mentoring activities may offer a range of health and well-being benefits to doctors. This study will prospectively and retrospectively explore the relationship between engagement in mentoring doctors' and health and well-being.

**We would like to invite you to participate in the second 'prospective' part of the study.**

This will track a sample of doctors (who are undertaking, or have undertaken mentor training within the past 2 years) over a 2-year period via a series of interviews. The interviews will gather information regarding your mentoring activities and any possible links to mentor and/or mentee health and well-being. You have been contacted because you have been identified as someone who has undertaken mentor training / or attended a mentor development course within the past 2 years.

**We realise that this sounds like a heavy commitment but we will make sure that interviews are held completely at your convenience (timing and location), or by phone if you prefer.**

An information leaflet with further detail about the study is attached and we would be happy to answer any queries you may have.

**If you are interested in taking part please reply to [alison.steven@northumbria.ac.uk](mailto:alison.steven@northumbria.ac.uk)**

Many thanks, Alison.

The email contained a brief project overview, a link to project information on the BMA website, and details of the procedure, as well as an attached participant information sheet providing further study detail. Individuals were asked to contact a member of the research team (AS) if they wished to receive further information about this study. After seven days, a reminder email was sent to those who had not responded, however, after this time no further emails were sent to participants who did not choose to participate in this study. Individuals that replied to the email were given the opportunity to ask any further questions, and an appointment for interview was made if they wished to go ahead.

All but one of the initial interviews were conducted face-to-face. Face-to-face interviews were carried out in the first instance to allow easy completion of the interview preparation document and to initiate the relationship between the interviewer and participant. As one participant could not be interviewed face-to-face, the interview preparations sheet was sent, and returned by mail, before a telephone interview was carried out. All initial interviews were slightly longer in order to build rapport between researcher and participant, and to gather all necessary information regarding training and previous mentoring experiences.

A series of up to four interviews was undertaken with each participant, at roughly 4-6 month intervals. Subsequent interviews were mainly carried out over the telephone due to the widespread location of the sample. All interviews (except for one individual who preferred not to be audio recorded) were electronically recorded using a Dictaphone, and transcribed verbatim.

## **Data management and analysis**

Data analysis drew on realistic evaluation principles and was undertaken using a thematic analysis approach based upon the aims of the study<sup>3,4,39,40,41, 43,45</sup> and using the BITC Workwell Model<sup>2</sup> as a broad coding framework.

### ***Data management: NVIVO***

Computer assisted qualitative data analysis software (CAQDAS) is recommended to assist qualitative researchers to store and manage their data. NVivo (an example of CAQDAS), which is able to manage a wide range of different file formats (word, pdf, media files, questionnaire data, social media and bibliographic databases) irrespective of the nature of their content; (e.g. interview data, journal articles, Twitter comments) was used in this study.

NVivo assists the researcher not just with the research process by facilitating the flexible organisation and management of research information, but also complements data analysis, with search and retrieve tools that enable the retrieval of identified themes in simple and complex ways. Visualisation tools such as charts and models enable displayed themes to be shared. Consequently, NVivo is excellent for demonstrating the research 'audit trail'<sup>71,72,73,74</sup> as it can help to illuminate the processes of thinking and doing in qualitative research<sup>75</sup>. The automatic tracking of the software can increase the quality of work by demonstrating "transparency and working systematically"<sup>76</sup>. The ability to demonstrate rigour in research provides additional benefit<sup>77,78</sup>.

However, there are concerns that some NVivo tools may lead the researcher to overlook, misguidedly, more appropriate qualitative approaches<sup>79</sup>, "exceed(ing) the limits of qualitative



sylogism logic."<sup>80</sup> and influencing the approach of the researcher<sup>73</sup>. For example, undue importance attributed to a theme based on descriptive statistics automatically provided by the software. New researchers may be particularly vulnerable in this regard <sup>80</sup>. Indeed, the use of some qualitative tools can influence the outputs in ways not realised by the researcher<sup>81</sup> which leads <sup>82</sup> to state the need to find a close fit between theoretical and technical aspects of the research. In essence, a clear understanding of the software architecture is important when using software in data management and analysis<sup>83</sup>.

In this project one of the team is highly experienced with NVIVO and this coupled with; episodes of reflection on data which were removed from the computer interface; multiple researcher input; scheduled group data workshops and discussions and final interpretation and abstraction done out with the software assisted in ensuring the analysis did not become software driven and remained grounded.

### *Analysis Process*

Immediately after each data collection point interview transcripts were transcribed verbatim and checked for accuracy. JW input all of the transcripts into NVIVO where they were initially coded using a series of broad labels drawn from: the BITC model; team discussions of the questionnaire findings and literature; and topics emerging from the initial interviews. At the outset of this study, we anticipated team-working (AS, GW, VL and JW) using the desktop version of NVivo. Subsequent access to the NVivo server enabled a 'free-range' approach to coding (JW) allowing additional areas to emerge inductively.

Data analysis direction was also discussed during meetings and early during the process a move was made from broad chunking to detailed descriptive coding; for example, Concepts of Mentoring holding participants perceptions of mentoring and operational processes, which categorised how mentoring was initiated and conducted. A more detailed approach was then incrementally developed as the project progressed and numerous detailed categories and sub-categories began to emerge. Participants referred to working through dilemma's such as work / life balance or juggling competing work demands, so further codes were created to capture this information and track , as far as possible, each mentor mentee situation as it unfolded. Further coding evolved to capture data reflecting both mentees and mentors emotional response to the mentoring process. Not all participants commented on how they felt about mentoring, while others could be very effusive, and often revealing developing insight and sensitivity in understanding people.

Simultaneously, the issues that mentees brought to the mentoring session were coded according to their focus using the general terms from the BITC Workwell model, for example; Better Work, Better Physical and Psychological Health and then defined more precisely.

In addition, alongside this coding composite vignettes were developed for each main theme. Although 'vignettes' take various forms in qualitative research and education, in this project they are employed as a way of documenting and presenting data <sup>68,69</sup>. There are three types of vignettes that can be used to present findings: a *portrait*; a *snapshot* or the type used in this study- a *composite* which depicts a mix of experiences amalgamated into a single all-encompassing narrative<sup>68</sup>. In this form vignettes are compact sketches based on a composite of data taken from multiple participants<sup>68</sup>, and also act as a mechanism for protecting participants in research such as this which

may deal with sensitive issues <sup>70</sup>. The vignettes combine elements and 'talk' from a number of participants who have dealt with similar issues or situations. Combining the participants experiences in this way helps maintain anonymity while illustrating and bringing to life the power of these real experiences, the interplay of factors over the period and the outcomes.

Whole team data workshops were held at several points during the course of the analysis, where possible all members attended (AS,VL,GW,JW,JS,NR) thus giving a range of perspectives on the data . These data workshops enabled the team to discuss, challenge, debate and theorize around the data and emerging findings, and to make sure findings remained grounded in the data.

Throughout detailed data analysis and discussion at team meetings, it was evident that the mentoring process had a number of noteworthy effects, both for the mentor and mentee and ultimately their employing organisation and care delivery.

## Findings

Participants described approximately 69 examples of mentoring being used to deal with different topics. The number of 'topics' dealt with by the participants over the duration of the data collection ranged from 2-15 per participant. These mentoring 'topic cases' were enacted through a range of mentoring relationships and activities. Participants described some 'mentoring' involving formal meetings, some ad-hoc meetings and all talked about using mentoring skills in a wide range of situations. Some mentoring relationships spanned multiple meetings while others were time limited and restricted to a one-off meeting some of which were mentoring 'taster' sessions at national meetings. A variety of initial topics were brought by mentees or tackled through the use of mentoring skills, however once explored via the mentoring process or skills, these topics were often found to be indicative of, or involve other less obvious issues - many of which clearly linked to doctors health and wellbeing.

Given the data findings were consistent across the data collection period qualitative findings have been amalgamated to avoid repetition and enhance the detail and complexity of the analysis. A number of interrelated themes have been identified from the analysis of the interview data, with the Business in the Community Workwell Model positioned as a lens to aid the analysis process and position the data findings. Each research theme consists of a number of categories and sub categories which share characteristics and connections. Drawing on the principles of realistic evaluation the research team identified and explored contextual factors and mechanisms which facilitated or inhibited a particular outcome (Research Theme). A representation of the research findings is presented below (Table 9) followed by, a detailed narrative of the research data.

Table 9: Interview themes and categories

	Themes (Outcome)	Categories (Context & Mechanisms)
Theme 1	Mentorship as a vehicle for better specialist support	<ul style="list-style-type: none"> <li>• Mentorship as support (M)</li> <li>• Access to mentorship (C)</li> <li>• Engagement with mentorship(M)</li> <li>• Mentorship enactment (M)</li> </ul>
Theme 2	Mentorship supporting better personal and professional relationship building	<ul style="list-style-type: none"> <li>• Relationship Issues brought to Formal Mentoring (C)</li> <li>• Informal application of mentoring skills to relationships (M)</li> <li>• Developing Collegiate relationships (M)</li> </ul>
Theme 3	Mentorship supporting better professional and personal well being	<ul style="list-style-type: none"> <li>• Threats to well being (C)</li> <li>• Mentoring Responses to wellbeing threats (M)</li> <li>• Mentoring Impacts on wellbeing (M)</li> </ul>
Theme 4	Mentorship supporting better working communities and cultures	<ul style="list-style-type: none"> <li>• Perceptions of existing communities and cultures (C)</li> <li>• Mentoring mitigating unsupportive workplace cultures &amp; communities (M)</li> <li>• Mentoring enhancing culture, community and care (M)</li> </ul>

## ***Theme 1– Mentorship as a vehicle for better specialist support***

The BITC Workwell model describes better specialist support as an early intervention mechanism, reflecting a proactive management approach to maximise employees' physical and psychological health. The data suggests the participants considered mentorship acted as a vehicle for providing such specialist support to medical staff. To facilitate such supportive mentoring relationship, participants highlighted staff needed to be able to access and engage in mentoring activities, develop and enact effective mentoring skills and techniques and build trusting relationships.

### **Access to mentorship**

The interview schedule commenced with a series of orientation questions in which participants were asked about their mentoring experiences as both a mentee and mentor. In response, the participants raised a number of issues concerning their access to and engagement with mentoring. The participants identified that a fundamental component of successful mentoring support, was being able to access mentorship.

*“And I said, “Well, you know, if you feel that you would benefit from further mentoring, I’m more than willing to do so. You’ve just got to contact me.” And he said, “Yes, that would be great. Because I found this really valuable.” PR 2*

However, the participants highlighted a number of mechanisms and contexts, which either facilitated, or more frequently impeded accessing mentorship within the workplace. Some of the participants suggested there was a lack of awareness concerning the availability of mentorship, which potentially stemmed from either a lack of promotion of the service, and / or potential mentees not being receptive to mentoring support.

*“I don’t think they’ve got a very high uptake for the service, and I think that’s because it’s not well-publicised.” PA 1*

*“I certainly think that we should be offering mentoring to all our newly appointed consultants. So, I mean, I think we have five or six, probably, in the last 18 months – I’m not sure any of those have come for mentoring. And so, you know, I think that would be an easy way in. And it’s just spreading the word then, really. But I think it is very difficult.” PJ 1*

Participant J concludes by alluding to difficulties in accessing mentorship. Several of the participants suggested prior understanding and perceptions of mentoring processes and activities influenced if doctors accessed mentoring programmes. This included perceptions of senior staff who may be able to promote the availability and access of mentoring support and potential mentees.

*“Because when we came back from the course, we approached our medical director, and it’s clearly it’s part of general... It’s generally seen as good practice, isn’t it? That there should be mentoring in most organisations. So we said that we were available. . . . And, you know,*

*he was very pleased – but clearly he really wasn't... He wasn't clear about what mentoring was. Because I think he was thinking of it as more a buddy system.” PJ 1*

*“So the GMC state that every new consultant should have access to a mentor. I think the main issue is that the new consultants aren't educated as to what they should use a mentor for. So I think during their induction it would be really useful to say, look, this isn't a punitive thing, this isn't because we think you're going to struggle. This is simply an impartial set of ears to listen to things and help you work through things if they are a problem. But it's not someone because we think you're failing. And that's the issue. And if a mentor comes up as part of an appraisal process it's seen as "Oh, God, here we go. That's someone..." And then, of course, if you're suggested that you have one they automatically feel that you're feeding back. Or writing a report at some point. So it's about educating.” PP 3*

In addition, the workplace culture may reinforce such perceptions as mentorship as punitive by utilising mentors and mentorship as a 'disciplinary' measure.

*“what they are doing now they have approached the mentors that have done the mentoring training at our hospital, to act as erm...first stage mediators in erm...into staff complaints.” PR 3*

Such approaches were felt by the participants to promote the perception that mentorship was just for 'doctors in difficulty' rather than a vehicle for support for all, which could influence mentorship access by associating stigma with seeking mentorship.

*“Again, there's a perception it's for doctors that are in difficulty, as opposed to it's first, sort of, general, just... Trying to be better at things . . . And the sort of almost... The informal meetings where you might get somebody saying is anyone willing to, sort of, mentor this academic trainee for a bit. You know, those sorts of things are perhaps less... Well, not loaded less... I think there's sometimes possibly a feeling that there could be some stigma for seeking mentorship,...?” PA 3*

There appeared to be a range of perceptions regarding when mentoring was or should be available to staff. Several participants appeared to consider mentoring was for senior posts, such as consultant.

*“And so one of the reasons that I decided to take up mentoring was because you had lots and lots of support as a trainee and then you would become a consultant and had absolutely nothing. And... So what I've... What I've found is that the trainees, that I used to look after as trainees and they're now consultants, but not in my specialty, have contacted me to see if I'll be their mentor as a new consultant. So I'm just about to take on a couple of other new consultants.” PP 3*

However, other participants suggested mentoring could be a valuable tool at various stages of the career pathway, enabling mentoring as a proactive rather than reactive mechanism.

*“then ideally we should be there not so much for rescue – rescue at the point of crisis – but much earlier as a point of progress. Much earlier in the forks and the stepping stones.” PM 1*

## **Engagement with mentorship**

The data suggested once access to mentorship was established, a number of factors and processes shaped potential engagement with mentoring opportunities. All of the participants described the preparation for mentoring they had undertaken, usually to prepare for a mentoring role.

*“It’s a two-day course, teaching the Egan model of mentoring. So it’s very practically-based. There are... There are, sort of, short teaching sessions, and then it... Like role playing. Where the teaching session is actually role played out, and then... When they split up into groups, and do the same within the group, and then at the end of the two days, there is a taped session between the trainee and a mentee. Which they tape and it gets marked. And as long as you pass, you get that... A certificate to say you’re Egan trained.” PR 2*

Participant M provides illumination regarding how and why one needed to engage in the preparation programme to maximise ‘authenticity’ and development of mentoring skills and abilities.

*“I had submitted to the process, and I thought if I’m going to gain anything from this, then it can’t be make-believe. It can’t be artificial. I want to test the process. And... Of course, bringing a scenario where my role is the mentee – so essentially it’s the mentor who practices or demonstrates, that gains the benefit. Or the observers do. And I... But I want... Obviously I would see myself how it would affect, and I would see an example of how I would resolve such a situation if I were sitting opposite me. So I did want the authenticity of it, and I was therefore willing to stomach the awkwardness of it, and the transparency of it. But I’m glad I did, because I found it... Useful as a problem-solving exercise, for me. And secondly to think, well, what...? What would I be like in the mentoring role, with people who might bring all sundry of issues to me?” PM 1*

This engagement was perceived to be a process over the duration of the mentoring programme, during which appreciation of mentorship techniques and its potential value as a professional support mechanism evolved.

*“people move from, sort of, either not understanding the model, or maybe being a bit cynical and grumpy about it, and thinking this is a load of rubbish - this is all a bit fluffy. And then you begin to understand it, and also think, oh, you know, maybe there’s something in this. Maybe it’s... You know, maybe it’s good. So that’s quite... That’s quite interesting - watching that develop from day one of the course to how the course goes on.” PN 4*

Other participants also highlighted the importance of mentee preparation, to enable mentees to quickly and successfully engage in the mentoring process.

*“So there's a training programme for the mentee as well as the mentor. For consultants, I think it's up on the website, but whether they've read it or not is a different matter. So actually part of most of the first meeting is actually explaining what this is all about. And what it's not about.”* PP 3

Following initial preparation for mentoring, the participants discussed initiating mentoring activity.

*“There's a group of us that all went on the same mentoring course, and we were all within the department of anaesthetics. I think there is... Four of us went on a course, and there was a previous mentor from the same course. So we've now set up mentoring of the anaesthetic department.”* PJ 1

Participants suggested overtime, and with increasing mentor numbers the momentum of mentoring activity increases.

*“We were about the third or the fourth tranche, when I did mine. About two years ago. We were about the third or fourth tranche of people who go through. But it seems to be picking up momentum now. In terms of the number of sessions and people that are being trained.”* PR 2

However, for several of the participants, they were unable to initiate mentoring activity.

*“I've not been a mentor for anyone . . . And when I've bumped into other people that have done the training, you know, in the street or in hospital, I don't think many of them have had any mentees yet, either.”* PA 2

Several participants suggested contextual factors, particularly funding and time constraints played a role in their ability to initiate and engage in mentorship activities.

*“I guess the only downside isn't my mentoring it is the more global thing in terms of the erm...you know a number of the mentoring schemes seem to be disappearing due to funding issues I think”* PN 3

*“We don't get provision for anything outside of the clinical timetable at all. So not even completing our e-portfolio or completing audits. And so all of it is done in our own free time. So it would all be outside of work. And with different... You know, different shift patterns and geography it's just difficult to commit to stuff.”* PG 1

In addition, for some, the ability to ensure a suitable location for mentoring activities, which facilitated privacy was an important contextual consideration.

*“we didn't have a private, private place to talk. We were just talking in one of our cafes, you know. But... That's sometimes the way these things are as well, if you don't necessarily have a specific office or somewhere to have a meeting like that.”* PA 3

## Mentorship enactment

The data suggested mentors utilised a range of techniques, skills and qualities during mentorship, which contributed to the effectiveness of mentoring as a vehicle for specialist support.

*“Anything that makes you a better communicator when you’re dealing with people is useful, you know. And anything that helps you help people re-evaluate their problems is useful. You know, so I think it [mentoring technique] was definitely valuable for a variety of reasons.”*

PA 1

For some mentoring relationships this included mentors needing to be sensitive and responsive to mentees’ individual needs and making appropriate adaptations to mentorship processes and timelines.

*“she was very emotional about the whole thing. She was in a quite fragile state. So, you know, there was quite a lot of tears and everything else. So what I didn’t want is to make any of the... The mentoring sessions overlong. Because, you know, I can remember when I was mentored about something that I wasn’t fragile about, it is tiring, really. And so we kept it so that it had a distinct, sensible end point. And it was a sort of package.”* PJ 1

The most commonly cited mentoring framework was Egan’s ‘The skilled helper’. The participants commented that the techniques inherent to the Egan Framework were frequently new to them and involved the mentors in stepping back from customary ways of thinking and behaving, which at times the mentors found challenging and the mentees surprising, as they expected more direct guidance.

*“the Egan framework was relative... Was completely new to me . . . it was a wonderful template to utilise.”* PM 1

*“Well, I think one of the problems that we all found, or certainly some of us found, was that in our jobs we’re very problem-solving based. And... I think that sometimes it’s a very difficult mindset to get out of. And I’m certainly conscious, when I’m mentoring, particularly, you know, if something is... You just want to say, “Well, clearly you should be doing this.” . . . you can offer a little bit of, oh, have you thought about this? You can suddenly go back to... But, yeah, I think it’s... I love... I love it when I haven’t done that. Yes, when I haven’t reverted to type.”* PJ 1

*“Because I think I personally have a habit of lapsing too quickly into offering advice. It’s probably an NHS doctor thing. That you know there isn’t very much time and you know what you’d do.”* PE 1

To enable mentors to apply mentoring frameworks, the participants suggested they needed to develop their skill set. Frequently this concerned utilising questioning and listening rather than advice-giving skills.



*"It's, well... I think the most important thing which I found the most difficult is keeping my mouth shut and not telling them what to do. So it's about listening and getting them to verbalise everything that's going on in their head. To look at the pros and cons with the right prompts rather than taking over the conversation and saying, you know, in this role, do you know what you should do or...? I'm very good at talking, unless I deliberately force myself not to. And partly through the training that was one of the most obvious things as well. So it was bits of clues like why don't you take a few notes or something which means you have to concentrate on that and not talk." PP 3*

*"So some of that [mentees questions] got thrown back at her, in the nicest possible way. Well, you know, who do you think you need to talk to? What is it you really want to...? What are you actually saying? Both in terms of physical geography as well as how are you going to develop the service, what does the service need? Because I couldn't answer that anyway, in terms of the expertise. That had to come from her." PO 2*

In addition, both mentors and mentees acknowledge the importance of building trust and confidentiality to maximise the success of the mentoring relationship in terms of offering specialist support.

*"Often if people come and talk to you, they're suspicious – what are you going to say? Are you going to report to someone? Gaining trust becomes more important. So once we felt comfortable with each other's company, then he started opening up." PL 1*

*"I've created a real safe zone for her. A trusted friend, and a person who is listening and believes in her, because a thing not being believed is a major issue in parts of the... spiral, that got her to where she got. PF 1*

To enact effective mentoring techniques and processes, including developing trust, a range of mentor qualities were felt to be important. These included being approachable, empathetic and non-judgemental.

*"Informally I'm... I have tended to be the go-to guy. Tended to be approachable in that people would confide, . . . I don't entirely know what it is about me that makes me approachable. I would guess that part of it is the... Good listening. I think... I would like to think it's being non-judgemental, which is a key to mentorship. And to drawing a distinction between advising and solving, and just the coaxing component of it. Teasing, if you like. And allowing them to solve their own issues." PM 1*

## Mentorship as support

All of the participants considered mentorship was supportive and several illustrated mentoring as providing a vehicle for enhanced specialist support.

*“A major specific [specialist] issue – I’m not going to go into details, if you don’t mind – but something that’s just now gone back into GMC at a really crucial time for [the persons]... Career. And, again, I think I’ve... I like to think, and I’m assessing that I’ve created a real safe zone [using mentoring] for [the person]” PF 1&2*

*“we went through quite a number of sessions.. I went through the mentoring process with him/her... in this particular instance, there was a clear element of bullying in the department... I said on a number of occasions, “I really think you ought to consider seeing your GP because there is an element of depression...I got him/her assessed by occupational health” PO1*

*“[in mentoring sessions] thinking about him/her referring [them]self to the professional support unit, only because I think [they] need a little bit more help than [mentoring] can provide... I think we’ve probably reached the limit [with mentoring] So, you know, [the mentee has] done enormously well. I think [they] found the whole process very helpful, in fact.... I think it [mentoring] just enabled us... to get signposted a little bit better” PJ2*

*If they've got something else... If they're genuinely troubled by whatever it is, then only my role is to... To gain their permission and agreement to pass them on to somebody who is specifically required to help them with that. You know, for example, if it was depression, you know, that's not... That's not for me [as a mentor] to deal with. But if I were to suspect it or if they were to volunteer it, then I would facilitate getting them the appropriate professional help. Yeah, so I'm a little bit of a... I guess a soundboard or, like, a traffic light” PM 4*

While some of the specialist support came from signposting mentees to other services (as illustrated above), much was in the provision of the mentoring itself. This provision of mentoring enabled mentees to access support focused on a specific issue- thus mentoring *became* the specialist support. However, the participants appeared to differentiate between support and its antithesis dependency, acknowledging the potential for the latter.

*“I wanted that we could support each other in the clinical environment and gain trust. At the same time, you need to be careful that you’re open to abuse. A dependency coming. And they [mentors] need to be wary that they don’t let it happen.” PL 1*

To avoid dependency some mentors suggested one needed to be clear about the intentions of mentoring, including acknowledging boundaries which included when to sign posting and / or referring mentees to other specialist support services.

*“It’s not going to go any further unless one says to them, as I’ve done with one person... In fact two, actually. We need a conversation about where we’re going to take this, how we’re going to get you out of this mess, and who we can get to help you.” PO 1*

The data presented in this first research theme has revealed some of the ways in which engagement (dependent upon availability), access (influenced by availability) and enactment (through activity) enable mentoring to acts as a vehicle for specialist support. The following vignette drawn from a number of participant accounts illustrates the way in which mentoring acts as a vehicle for specialist support.

### **Composite vignette of mentoring as specialist support**

#### *Context:*

I had done a mentor preparation course about 18 months ago and been involved in the Association scheme since then- even though resources were often stretched and I usually ended up using my own time to have mentoring meetings, and sometimes away from the hospital.

So this person had to have some time away from work and was dealing with very difficult situations and I think, as a result of that, they also lost confidence. They’d had a lot going on in their life - work issues related to complaints and personal life events.

When they came for mentoring I think their plan was to be mentored about how to have the perfect CV and how to get the job they wanted on return to work. But I was conscious of the fact that this person was very emotional about the whole thing and it was quickly clear that we should deal with the biggest issue first.

#### *What mentoring process did:*

I did each stage of the (Egan) mentoring model per session and I didn’t make mentoring sessions overlong as it is tiring, really. We had the first two mentoring sessions within a week as this person was quite fragile.

It became more complicated as the mentoring went on as it seemed the person was quite unwell, and perhaps fairly severely depressed. So I think it was a more a complicated process than just mentoring. We discussed self-referral to occupational health, the professional support unit and advised going to the GP, only because I think they needed a little bit more help than I could provide. I think we’d probably reached the limit.

#### *Impact/outcome:*

The person did self-refer and got appropriate medical help so I didn’t see them for a while, so, yeah, at the time I was anxious, but then they came back to me for further mentoring which was really nice. Achievables and SMART goals were difficult at first but we did get to there. This person was just going through an unfortunate blip at that moment and needed specialist help and it was my role

to facilitate them getting that specialist help. It was great to get feedback that it was the mentoring sessions that gave them the impetus to get expert help. Their response has been very good and they are much, much better and have certainly come through the worst of it. They've done enormously well and the impression they give it that it's resolved.

I think he/she found the whole process (the mentoring and the specialist help) very helpful he/she's certainly on track now. I've told the person that I think they are a fantastic investment for the NHS, really, and just because they were not very well at that moment, it doesn't mean anything in the long term. So I think they found mentoring, pretty powerful. I think mentoring just enabled him/her to get signposted a little bit better.

## ***Theme 2 - Mentorship supporting better personal and professional relationships***

The data suggested a frequent outcome of mentorship was the enhancement of personal and professional relationships. This included relationship issues, which were brought to formal mentoring interactions and ad hoc application of mentoring skills to develop collegiate relationships.

### **Relationship Issues brought to Formal Mentoring**

Several participants described issues raised in formal mentoring sessions as relating directly to difficulties experienced in professional or personal relationships. Some issues involved collegiate relationships where the mentee was seeking ways of dealing with difficult interactions.

*"He/she was having difficulty with one of the [specialty professional] individuals" PL1*

*"What's the best way to describe it without breaking confidence? - Care management. So it's about someone... Has got issues with both their role and service, that's changing, and doesn't know what to do about it, really. ...So what to do themselves, in terms of moving forward. How to deal with... Manager / colleagues – difficult relationships. It's kind of about that" PE1*

*"He/she skirted around the relationship he had with [their] current bosses" PR1*

*"many of them were work-related issues... Issues of conflict. Sort of, I would put it under the title of conflict resolution, issues of clashes" PM 1*

*"In fact, I was asked [to be a mentor] because it was a registrar in a small department who was having relationship problems with the department head and other doctors in the department, a professional relationship [problem]" PO1*

*"one of them [mentee] has alluded to how stressful their job is. And how difficult and challenging and... In terms of the dynamics within the team. ...Yes, [relationships] and...having a stressful job and then working within an environment, in a team that isn't functioning properly. And not knowing necessarily where to turn. That can be quite... Quiet challenging" PP4*

In response, mentors used mentoring techniques to assist mentees to review, reappraise and find potential ways of responding to relationship issues.

*“Unfortunately some of the criticism was probably fair, and trying to deal with, you know, maybe the way that, maybe, you feel very aggrieved and maybe the way that this has been handled has made you very annoyed and angry. And, yeah, you’re very pissed off about this. But... You might want to action on this. And I tried to steer her to that without saying, “Are you sure they’re not right?” It was really tricky.” PB 1*

*“I think I used the term what is bugging you while you’re working here. And are you feeling the rough edges, somebody is trying to wind you up and you feel challenged. ...we can talk it out and then we can work it out, what is the individual response, what is the organisational habit. And if it’s organisational habit you have to put up or shut up. And just talk it out. If it is individual, that can be modified. And one way to modify the change in your own behaviour, if not other person’s behaviour – you can change other people by changing your attitude. Your response to it. Otherwise it becomes tit for tat. And I think that that [using mentoring to explore these relationship issues] worked very well” PL1*

### **Informal application of mentoring skills to relationships**

Relationships were also a driver for ad hoc mentoring opportunities and the use of mentoring skills out with formal mentoring sessions. Participants identified using their mentoring skills in a range of informal situations within the workplace.

*“People sort of ask my advice on everything else. And, you know, I try to point them in... Rather than me giving them advice, I usually sort of get them to try and... You know, as [Name] would say, you’re sort of getting down and dirty and quick mentoring – quick corridor mentoring – sometimes is what’s needed.” PJ 2*

This included providing opportunities to colleagues who were unlikely to engage in formal mentoring but who benefitted from a mentoring approach.

*“I don’t want to call him belligerent, but that is sort of part of his personality. So, you know, again, he’s not somebody that necessarily, you know... I don’t think he appreciates anybody thinking he was failing horribly or weak or anything else. And so I think he would have found it very difficult coming to me, maybe. But me going to him and just chatting about stuff enabled him to come to, possibly” PJ 1*

Such informal use of mentoring skills, was often aimed at enhancing professional relationships. These opportunities often involved a range of colleagues from diverse professions and in situations, which were not restricted to one to one interactions.

*“It goes on pretty much... Definitely informally in... In quiet corners when we catch up with colleagues, either of the same specialty or... Or not. And it’s either consultant or trainee. And it could also be not even within medicine. So it could be other healthcare professionals.” PM 3*

In addition, the participants identified using mentoring skills and techniques within personal relationships and situations, out with the work environment.

*“My[spouse] has just had a big work promotion. So he/she’s now got a poison chalice of a job which is cross-site and... So I’ve noticed that I need to be a different sort of [spouse] these days . . . So in terms of tapping in to those... Into that [mentoring] skill set, you know, it’s amazing how... How useful it is . . . the same mentorship skills that I would use to support him/her” PM 3*

However, the attempted use of the skills and techniques was not always successful, particularly with participants’ children.

*“And I use it with the kids as well [laughs]. But that doesn’t seem to be as successful, because they’ll just tell you to go away.” PP 3*

### **Developing Collegiate relationships**

The application of mentoring skills and techniques was considered as changing formal interactions with colleagues.

*In terms of going through, kind of, the Egan skills, helper model and formally mentoring in that kind of way, I really do... I mean, that’s [learning the mentoring skills and model] changed the way I formally interact with lots of people [in work settings]. PP 3*

This view that mentoring skills and knowledge influence collegial relationships overlaps with the idea of mentoring as facilitating supportive cultures. While 1:1 professional relationships were often discussed during the interviews references were also made to mentoring as assisting group or team relationships.

*“one of the things that I’ve already experienced in these, sort of, last few months of mentoring, is that department dynamics are probably the biggest problem the NHS has. Because the culture is far from supportive...It’s not mentoring at an individual level – it’s... Oh, it’s team-building, isn’t it? I suppose. You know, if we want to try and sum it up in two words, it’s trying to get people to understand [using mentoring] that you need to work as a team.” PO.2*

This use of mentoring both in formal and informal situations was perceived as positively developing collegiate relationships in the workplace, because of enhanced communication and promotion of conflict resolution.

*“Most conflicts are flawed communication. So if there was an appetite for resolving the communication issue, which is often the style in which something was said rather than necessarily the substance, then there would be much more resolution of what appears to be the conflict. It’s often misunderstanding. Not necessarily blown out of all proportion, but that is the... That is the crux of it. And so, undoubtedly, mentorship does [contribute to conflict resolution].” PM 1*

This second research theme has presented data that explores the relationship issues brought to formal and informal mentoring interactions, developing collegiate relationships. The following vignette drawn from a number of participant accounts, illustrates the ways in which mentoring supports better personal and professional relationships.

## Composite vignette of mentoring as supporting better personal and professional relationships

### *Context*

It was to do with changes in service configuration, patient management and relationships. This person came to me for mentoring as they were having difficulty with one of the consultants and their relationship was impacting on the provision of services. They wanted to work out what to do in terms of moving forward.

### *What mentoring process did:*

We met several times for mentoring and once the trust was established and we felt comfortable with each other's company, then she/he started opening up. The difficulty was in a relationship with one of the specialists around changes in patient management. The mentee felt patronised and thought the specialist was being obstructive- they felt their role was not appreciated, in short they felt 'put down' by this particular specialist's tone. A lot was to do with style of communication, misunderstandings and things getting blown out of proportion. Everyone was under stress in that service area which was compounded by service changes.

So in working through the model during the meetings I prompted this person to think about the interaction with this specialist and why they felt the way they did, to also think about the context and put themselves in the other persons place, in that situation. I just said, you know, think from their point of view. The mentee came to the conclusion, worked out for themselves during the mentoring, that perhaps this was largely a communication issue, a misunderstanding and the one thing they could do was talk to that person.

We talked about explaining what was going on and ways of doing that explaining; not being confrontational, defensive or accusing - not saying, "I don't want to be pushed around" and he/she decided if he/she explained these things in this way, then it might work out.

### *Impact/outcome:*

So he/she felt comfortable with my mentoring and the discussion and it seemed to work, the mentee later said the relationship was better and thinking about the ways of explaining had helped. They had talked to the specialist and recognised that there had been a misunderstanding, and also perhaps part of the reason for the specialist's tone and indeed the mentees response to it, was prompted by the amount of pressure they all felt at that time.

Their relationship did seem to improve- which all helped the service change become smoother and they seemed to be getting along much better, which I guess in the end also impacted on other staff and ultimately the patients.

### ***Theme 3– Mentorship supporting better professional and personal well-being***

All of the participants identified and discussed actual and potential situations and contexts in which mentorship had affected their professional and personal well-being. Potential threats to wellbeing were identified, as were a range of mentoring responses to wellbeing threats. The majority of the data suggested mentorship responses enhanced professional and personal wellbeing for both mentor and mentee, via the processes and mechanisms developed and applied to mentoring interactions and the positive feelings engagement in mentorship generated for the participants.

*“There’s a few things to it [mentoring]. One, you’re doing something good, hopefully, for people. Two, you’re perhaps helping people, you know, at a tricky time, or helping people at... I mean, it should really be a positive thing – for seizing opportunities or stuff like that. And I think seeing how other people cope with things may perhaps give you an insight on your... One, how good your lot is. Or, two, how to help yourself. You know, so I think these things are all, you know, worthwhile and useful.” PA 1*

#### **Threats to wellbeing**

The participants identified an abundance and range of examples of threats to their wellbeing, which necessitated mentorship support. The most frequently cited were work related stressors, which participant L considered may potentially have both negative threats to wellbeing and the potential to develop resilience.

*“Work – if it doesn’t kill you, it makes you stronger. But then what happens if it kills you beforehand?” PL 1*

The stressors’ identified in the data included the nature of the work undertaken by doctors, particularly dealing with emotionally demanding situations. Mentorship was considered to provide the opportunity for mentees to discuss the intense emotional situations they encountered and the thoughts and feelings these encounters evoked for participants.

*“Just something else going wrong. Because she’s blamed herself. You know, any sort of remote things going wrong, which aren’t her fault at all – they’re just sick patients, really. But, you know, you are dealing... You know, the part of the training that she’s going through, she’s dealing with the worst emergencies that we get” PJ 1*

*“And I don’t know whether, you know, it’s development – but I think a lot of people just appreciate having that time to talk things through. You know, it’s kind of time out and time where they’re allowed to talk about their, kind of, feelings or ideas for things without any judgement whatsoever. With essentially most of the time or often a stranger. I think we probably don’t have that opportunity and we all... Or, you know... There’s a lot of pressure. And perhaps it’s nice to just be able to take some time out from all of that and be able to talk about feelings and things.” PG 1*



Many of the participants highlighted work related stress associated with increasing workload and demands placed upon them in the workplace as threats to their wellbeing.

*“When I saw her first it was all about workload. Really. And feeling guilty. She was working more... When you worked out her sessional hours, they were grossly in excess of what she was being paid for. And she’s also trying to do a PhD. So... The problem had developed around the fact that the hospital altered the way it wants consultants to work. . . it was affecting her health . . . she was losing sleep, she was anxious, she was worried, she wasn't concentrating on the things that she should have been concentrating. . . . And I think she found the mentoring helpful because it gave her a base every now and again to come and offload, discuss some of the problems, what the likely outcomes might be and how that might, or might not, affect her position within the organisation. The fact that she could talk to somebody who was outside of the organisation... I think, was particularly... really, really important.” PO 1 & 4*

The participants identified threats to wellbeing also arising from career related stressors. This included promotions, with suggestions that increased expectations upon senior medical staff exacerbated the degree of stress experienced.

*“So he was, you know, multiply qualified already. Very academic. Very high achieving. And I think had sort of come to a point where his work-life issues were overwhelming, really. He was desperate to do terribly well in [professional area] and... Which he was doing. But I think he was struggling a fair amount with the stress that it was inducing in him.” PJ 3*

The data highlights the holistic nature of wellbeing, with personal life stressors affecting the individual’s work and work related stressors affecting the individual’s personal life and associated perceptions of wellbeing. Participant J highlighted a previous mentee who had experienced a number of personal events including bereavement which participant J considered affected the mentee’s wellbeing and ability to work effectively.

*“You need to be... You know, sort of, functioning at 80% just to deal with that sort of thing [work related demands]. Anything less than that and you would start struggling. And I think [the mentee is] probably functioning around about 30%. But I’m sure [mentee will] make progress. I’ve no doubt about that.” PJ 1*

### **Mentoring Responses to wellbeing threats**

The participants suggested mentorship supported better professional and personal wellbeing by enhancing the ability of those involved in mentorship to respond to wellbeing threats. This included mentors employing mentoring skills and techniques to facilitate mentees developing new insights and solutions to issues that could affect their professional and personal wellbeing. This included prompting mentees to express concerns, so they could explore and view them afresh.

*“I think it is good to bounce problems off, and I did find that quite useful to do. I think the most helpful time I was actually doing it was in the proper mentee-mentor thing.” PA 1*

*"I think that the benefits I feel of thinking out loud and emptying one's head gives one this... It's then all a bit like you tip a pack of cards on the floor, and then you gather them in some sort of order, and then put them in their suits and in numerical order. And it's just the process of doing that gives it a different structure." PM 1*

The data suggests mentoring can enhance the mentees' response to a range of wellbeing threats including workplace threats to wellbeing, such as high workload and concerns regarding workplace relationships.

*"From the point of view of the mentee. We were just chatting in general and I sort of... I suppose I just threw at her, well, "Have you actually talked to your head of department about this? [excessive workload] You know, and what's his or...?" I think it's a him, but... "What's their...? What's their viewpoint, or what are they doing about it?" Sort of thing. And she looked at me – she obviously thought I'd completely lost it – and looked at me and said, "You know, you're absolutely right. I haven't spoken to him about it at all." You know, and you sort of think, well, that's a good starting point." PO.1.*

*"And also helped him to use his energy and time in a more constructive way – if I can put it that way. Rather than trying to struggle to fit in and then getting very over-burdened . . . And just talk it out. If it is individual, that can be modified. And one way to modify the change in your own behaviour, if not other person's behaviour – you can change other people by changing your attitude. Your response to it. Otherwise it becomes tit for tat." PL1*

Some of the participants acknowledged using mentorship techniques to 'self help' them respond to stressors they encountered.

*"But I think sometimes I get a bit... I lose sight of what the actual problem is and you can feel very stressed about something. And it all gets a bit muddled in your head as to what the actual crux of the problem is. So I think I've found it kind of useful to actually think, okay, what actually is the problem that I need to solve? What is the actual issue? Which I think has been... Yeah, has been really quite useful. And I've probably used it most like that, really, to be honest. To actually kind of, yeah, really pinpoint." PG 1*

*"I found the [mentoring] course so useful, I was.. going through a really difficult time as \*\*\*\*\*[role]. my thoughts were all tangled on what to do, what not to do. And just learning this model...during the first two days I kind of made decisions and acted upon them. So it immediately untangled my head. ... What is the problem? Which bit you have control on. What can you do, and by when, to stop that particular stress? And I genuinely, as if something clicked, and the actions I took then, x months on, were crucial. If I hadn't done it, I would have either gone off sick or I wouldn't have had the documentation that [I needed]... And that's why, x months on, I look back and I think what an amazing breakthrough that moment was [learning about mentoring]" PF*

## Mentoring Impacts on wellbeing

The data provided a number of examples of how mentorship had affected the well-being of mentees and mentors, including psychological health.

*“But basically, you know, I came to mentoring about the same time that I went less than full time, primarily because things were going really badly. And I certainly considered myself at the time to be a failing trainee. And was really struggling my way through. And actually, some of the [mentoring] sessions I’ve had, some of the time I’ve spent, has been incredibly valuable in terms of psychological wellbeing. And, in fairness, it would be useful to kind of continue.” PB 1*

*“[person] came for mentoring .. about, the perfect CV .. And it was quickly clear that that wasn't appropriate for mentoring at the moment..[the person was] very emotional .. in a quite fragile state.. . And just because [they] are not very well at the moment, it doesn't mean anything in the long term. So I think he/she's found mentoring pretty powerful. And it's clearly been very emotional for them” PJ*

Many suggested mentoring had enhanced their insight into issues and concerns, which were influencing their professional and / or personal wellbeing. This enhanced insight, enabled the mentees to respond more constructively to potential work related stresses, suggesting the development of resilience strategies.

*“It probably just enabled me to be a bit clearer minded in what I actually probably knew – if I was honest with myself – was the right thing to do. But then I guess that feeling that I properly thought about it all empowered me to kind of say... Say no. After feeling like I'd thought about it constructively. And almost... I guess I felt a bit more equipped in how to, kind of, say no, without feeling that I was letting anybody down.” PG 1*

This helped mentees to re appraise some of their professional and personal concerns and contributed to mentees feeling generally more positive about themselves and the workplace.

*“I was quite miserable – just really pissed off with the way my training was being hijacked. [Following mentoring] My training was still hijacked, I was still pissed off, but I maybe went from a pissed off of 9 to a pissed off of 6 or 7, you know. But that was still... Still a significant reduction. And then I had a chat with the mentor. And he sort of suggested a couple of things about ways to think about the job. And I was like, right, I'm going to do that. And actually doing that helped remarkably. And has continued to help. Do you know, I think it was just a good, ... Sort of... Values realignment-type thing, you know what I mean? So I think that was good.” PA 1 / 2*

In addition to mentees identifying wellbeing impacts, some of the mentors acknowledged that engaging in mentorship as a mentor had enhanced their insights into their professional and personal skills and attributes.

*“So, for me, the value is in knowing my own personality, gleaning the personality of the person I am working with or for. So I will be working for a patient, but there's just such a snapshot. And then I'll probably never see them again. But with a colleague, be it a fellow*

*clinical colleague or a healthcare professional, an allied healthcare professional, and I work with them for maybe a decade. And then developing the relationship is, I think, fundamentally based on an understanding of the personalities and thinking, well, based on my personality and your personality, this is where we would conflict and clash. But this is where we would fit and engage. We would be more cohesive, more cooperative. So if I'm the... Out of the two of us, if I'm the expert because I'm the enthusiast in the material, then the responsibility is on me to adjust my personality to accommodate theirs."* PM 1

The data suggested that many of the mentors also felt more positive because of engaging in mentoring others, as they enjoyed the mentoring role.

*"It's something I enjoy. I enjoy talking and talking [Laughs]. And lecturing and, you know, supporting people, really."* PR 2

This enhanced positivity expressed by mentors appeared to be associated with mentoring others providing enhanced role fulfilment and satisfaction, with mentors perceiving they were valued and able to help mentees achieve goals.

*"Plus, it's of huge benefit to me [mentoring]. It's a huge benefit to me in terms of feeling valued, feeling my worth, aspects of one's self. Be it worth or esteem or knowing. And then you can... Because then there is a bit... This sort of veneer against all that is out there, that demoralises and leads to a disillusioned workforce. So I feel somewhat protected, or armoured – armour-plated – against what is out there that others might succumb to."* PM 1

*"Oh, I've loved it. Yeah. Yeah . . . Especially with the outcome that happened. You know, I saw him move on to something that I... I felt that... You know, it was something he wanted to do. And it came from him, which is what the Egan model is all about. So, yeah . . . The degree of satisfaction that... In that, you know, he'd done what I think he'd wanted to do."* PR 2

In addition, mentor G highlights involvement in mentoring has provided professional opportunities, for the mentor which enhanced their feeling of wellbeing.

*"I would say that's increased my wellbeing in that sense. I've had opportunities through mentoring to, you know, go to [XXX] and mentor in other regions. And, you know, got involved with a bit more, kind of, teaching and well, kind of, facilitating others using the model which has been good. And I think from the feedback that I have had it's all be very positive."* PG 1

For those mentors approaching the end of their careers this included a sense of stepping back from more clinical roles whilst maintaining engagement and fulfilment in such a way as to promote the wellbeing of the subsequent generations of medical staff.

*And the selfish bit, I'm absolutely willing to concede is that I can't continue to anaesthetise the way I currently do. So, in ten years' time, I think I'll be done. I'll be spent. So I wouldn't really want to be doing it on-call. I wouldn't really want to be doing long days. I wouldn't really want to be doing emergencies and very sick patients and what have you. And I think, gradually, my appetite and ability to do those professional bits of my job will diminish.*

*Because I've seen that in others. I've seen that in my colleagues. But... So I am genuinely looking for something which extends my working life, that gives me as much fulfilment, professionally, as I currently get from anaesthesia. And that's, I think, what I saw in this.* PM 1

However, not all mentoring interactions appeared to enhance mentors wellbeing. Several mentors provided examples of occasions when involvement in mentoring had a negative impact upon their wellbeing. Commonly mentors suggested mentoring could elevate levels of anxiety, as they worried about a particular mentee and / or the situation discussed by the mentee. This led some mentees to question if they had the skills and attributes required for mentoring.

*"And then I worried for ages and ages because nobody would tell me what had happened. So the person who had asked me to get involved wouldn't talk. The person who I was involved with wasn't available. And, in fact, I can remember saying to [Name] who was leading the group in the first session, I wasn't sure whether I was really... Whether I should be doing mentoring. It's... I don't know whether I've got the... I'd have the ability, whether I've got the... The makeup, the patience, to do mentoring. I wasn't too sure about. And I was also worried about the outcome in this particular case."* PO 1

However participant J, acknowledges such anxieties may persist and possibly be exacerbated without mentorship.

*"I suppose I've been worried about the most difficult mentee that I've got. The one who's got the greatest difficulties, rather than difficult mentee. But I think it's... I would have those anxieties about him/her just because I'm one of his/her consultants. It's not necessarily because of the mentoring. I think the mentoring is helping his/her find a way through this"* PJ 1

Some of the participants suggested dealing with potential mentoring anxiety involved developing and enhancing mentoring skills, to differentiate mentee and mentor concerns. For participant B this involved self-mentoring.

*"Well, I've gained plenty out of the skills set to be able to actually deal with problems without taking them on board. And that's quite useful. And that's something I use bits and pieces of going on. And I certainly do use bits and pieces of mentoring, you know, when people do present you with problems that are theirs. I'm, I think, a lot better at leaving them with the problem, than taking it on and making it mine. I also... I think, I'm slightly better at use a... Just, kind of, trying to use more sensible decision-making processes, rather than just jumping in with everything without thinking. To actually kind of mentoring myself occasionally."* PB 2

Theme three of this research has revealed a range of situations and contexts that may threaten the well-being of the participants. In addition, the data has illuminated the mentoring responses and potential impacts that may have on such well being threat, suggesting mentorship may support better professional and personal wellbeing. The following vignette drawn from a number of participant accounts illustrates the ways in which mentorship supports better professional and personal wellbeing.

## Composite vignette of mentoring as supporting better professional and personal well-being

### *Context:*

Some people in particular can find it very difficult to seek support formally and do not like the idea of anybody thinking they are failing or weak, or anything else. This colleague is like that and would have found it very difficult at the start to come to me formally in my mentoring capacity, but me just chatting about stuff in the corridor and using my mentoring framework and skills in the conversations, enabled that person to actually make a decision to come for mentoring.

This mentee's issue seemed career-related, but ended up being very much about dealing with far too much, plus a family and feeling overwhelmed by trying to juggle career and family life. It was soon clear they had experienced a couple of bad cases and come to a point where work-life issues were overwhelming and they were really struggling with the stress it was inducing; tiredness was also a factor. This person expressed feeling burnt out - it can affect most of us really and I think we're all very bad at seeing that.

### *What mentoring process did:*

It was around a year's worth of mentoring, so about every 6-8 weeks or so we had a mentoring session. Using mentoring skills and the framework and through those conversations the person seemed enabled to actually unpick things, make a plan and some decisions, to tackle their workload in terms of the wider team they worked with, have time away and a holiday - and more importantly it was the decision that made them happy, and resolved the problems at the time.

People such as this mentee like something quite concrete from mentoring such as a timeline with the set list of things to do that feel very achievable. Because a lot of the time they are dealing with that overwhelming feeling of not really knowing where to go next.

They like a relatively short session, 45 to 60 minutes, you can get away from a feeling that you can't even see what the problem is and end up with a very concrete plan that you can hopefully do some of. That's what a lot of people have found useful.

### *Outcome*

So now that person is fully back and confident again. I think the mentoring took this mentee through quite a challenging time and gave quite a lot of opportunities to try and reflect. They got a lot out of it. So as far as what the person approached me about, that seems to have resolved now. So I think mentoring helped them probably come to terms with what they needed to do at the time.

## **Theme 4 – Mentorship Supporting Better Working communities and cultures**

The fourth and final theme emerging from the data involved contexts and mechanisms that highlighted the potential outcome of mentorship supporting better working communities and cultures. The participants identified and discussed their existing practice communities and culture and suggested mentoring could mediate unsupportive contexts, enhancing the culture, community and ultimately patient care.

### **Perceptions of existing communities and cultures**

Participants described their existing practice communities and culture as largely unsupportive, with some participants perceiving there was limited sense of community

*“one of the things that I’ve already experienced in these, sort of, last few months of mentoring, is that department dynamics are probably the biggest problem the NHS has. Because the culture is far from supportive . . . And I think it’s far, far wider than that. It’s not mentoring at an individual level – it’s... Oh, it’s team-building, isn’t it? I suppose. You know, if we want to try and sum it up in two words, it’s trying to get people to understand that you need to work as a team.” PO 2*

*“Oh, without doubt it’s [support] lacking in medicine in generally. Totally. You know, you’re supposed to show no weakness, I think, as a rule. If you show weakness... It’s very much dog eat dog, without a doubt. You know, there is... There is not much room for people to fail, I think, you know. There’s no option. And considering we work in a caring profession, that we don’t care for each other very much at all, really. Which is a bit disheartening.” PJ 1*

*“That’s the other thing – I think the old-fashioned firm structure in the NHS has gone. So often, if you were happy at work, you ended up working with someone that trained you. And you knew all his weaknesses and strengths. And, if you were lucky, you ended up working in his department. And no matter how much you liked or disliked him there were certain things that you thought, I value his opinion. I’m going to knock on his door and I’ll say, “This is what’s happening. In your experience, how should I deal with it?” I think that doesn’t exist anymore. Because we took that... That, sort of, pyramid and flattened it. And... So nobody in the department is given the respect of eldest anymore. So, therefore, they don’t act like that. They’re kind of dog-eat-dog, you know. You’ve got a problem – deal with it.” PF1*

Participant M considered the medical community of practice did not having access to the same range of support mechanisms as other professions.

*“But there are also other things that we never had. Educational supervision, we never had. One-to-one coaching we never had. Mentorship. And it... And ironically the medical profession is pretty far behind the rest of the corporate world, and probably the rest of the health service”. PM 1*

Participants suggested that this unsupportive workplace culture led to a need for quick responses and a focus on self-preservation, which in some instances appeared to result in staff offering silent compliance with entrenched organisational responses.

*"I think everybody is self-protecting" PF 1*

*And then we can work it out, what is the individual response, what is the organisational habit. And if it's organisational habit you have to put up or shut up." PL 1*

*"I sometimes sit and think, "Is this...? Even though this isn't a formal mentoring relationship, do we work through the "I'm not going to tell you what I'd do, or what I think the answer is, you're going to talk through it yourself"? Or at what point do I recognise that it's five past four, I've got 150 other things to do?" And actually we could reach a point where I just say, "There's two options – you do this or you do that. And if it was me, I would do this." PE 1*

In addition, that data suggested working within such uncaring cultures was perceived by participants as not conducive or supportive to maintaining a healthy work life balance. In response, work life balance was a common focus of mentoring interactions.

*"most of the time it's juggling work-life issues. That would be the general flavour [refers to mentoring sessions]. So, kind of, not knowing how to prioritise things or whether to say yes to things. How to say no to things. Kind of deciding which projects to become involved with. Feeling overwhelmed by trying to juggle, kind of, career and family life" PG 1*

*"After about 6 months I...[in mentoring relationship] I had to prize her open and say, to me, it looks like you're not comfortable in your position. Have you got a problem at home? Or is the problem with colleagues? "Why do you say that?" I said, "I don't know anything. A hunch... I may be wrong." And then she said, "Yes, this, this, this... My daughter is getting very edgy. She wants me at home at certain times. Therefore I can only work for three days. When I work for three days, I come in and clash with colleagues, because what they do is, when I'm not there, they don't see any patients. They leave for me when I come back. And when I come back, I have to do all the catching up. And because I'm doing the catching up, I can't do my current work. And it just piles on. And when I go home, I'm absolutely dead to her." PL 1*

## **Mentoring mitigating unsupportive workplace cultures & communities**

Participants suggested that mentoring could act as a mechanism to mitigate the effects of an unsupportive workplace culture. It assisted mentees in understanding and situating themselves within the workplace culture and to re-frame their position within the community of practice. In addition, mentoring also facilitated reflection on the ways in which other individuals within the community responded to and dealt with organisational pressures.

*"Yes. I think he did say that it [the mentoring] helped. I asked him, you know, was it that useful or just an exercise on paper – the mentee-mentor. He said, no, it helped him to settle down. And also helped him to use his energy and time in a more constructive way – if I can put it that way. Rather than trying to struggle to fit in and then getting very over-burdened." ... He was having difficulty with one of the [staff member]. ... So I said to him, okay...*



*That's normal behaviour for that particular individual. Because we have worked with [X], and it's no different. And can be very abrupt. But you... If you put yourself in [X] place . . . – why the individual is doing it, you will find that they will say they're doing their job best and for the best of that patient that they want to get through the list. That's why they're behaving in that particular fashion . . . In that mode [implies mentoring] I just said, "You know, think from [X] point of view.." PL 1*

Access to mentoring activities also helped individuals manage competing priorities impinging upon their work life balance by developing insights as to the key issues and creating a plan of action.

*"I think a lot of people like the fact that it ends in something quite concrete – so the timeline with the set list of things to do that have been... That feels very achievable. Because I think a lot of time it's that kind of overwhelming feeling. Not really knowing where to go next. When a lot of time, because it's often work-life balance issues, you feel like you don't have a lot of time to even sort of read the solution. So I think people are bound to the fact that actually in a relatively short session – you know, 45 minutes, 60 minutes, maybe – you can actually go from feeling that you can't even see what the problem is to having a very concrete plan that you can go away and hopefully at least do some of. So I think that's what a lot of people like the idea of. And have found useful." PG 1*

## **Mentoring enhancing culture, community and care**

Participants implied and suggested that mentoring facilitated the development of cohesive and supportive communities of practice.

*"Sometimes they [colleagues] just come after a bad day. ..I end reminding them that, yeah, that happened and it wasn't brilliant. But, actually, the rest of the day was good, wasn't it? Kind of thing. And talk about what has gone well. And what we're going to do tomorrow. So it's not formal [mentoring], let's go through the model and all that. But... But just learning how to change someone's mood before they [go home]" PF1*

*Yeah. I think it does. And I think that, you know, there must be a tipping point where people feel, well, this is a supportive department or this is a supportive team. And I feel like I belong and... And all those sorts of... PM 1*

This sense of cohesion was considered to be derived from application of mentoring skills, particularly those that improved communication, which enhanced individuals' sense of belonging to, and being valued as part of the community.

*"And I think it's... It [mentoring framework and skills] helps with communication on all levels, really. Because it does improve listening. And so I think for meetings things like that I'm more likely to listen for longer. And then also often recap what somebody was saying. Just to make sure that they knew that they would be listened to. And that I've got the*

*message right as well. So I think for facilitating meetings it's been a quite helpful skill to us. But I think they're [mentoring skills] helpful in life anyway" PJ 1*

*"I've told her that I think she's a fantastic investment for the department, really. And just because she's not very well at the moment, it doesn't mean anything in the long term. So I think she's found mentoring, again, pretty powerful." PJ 1*

*"I think I changed the way I listen. Because I've felt the power of being listened to for the first time... I found that so powerful. So powerful [learning the structure and process] And... I can honestly say from that day one and two, no other conversation I had was ever the same again" PF1*

In addition, a cohesive community of practice may foster a trusting and emotionally 'safe' practice context. Feeling safe within the community can enable participants to raise concerns, ultimately benefitting organisational function including patient care.

*"I don't see many happy doctors anymore. Because it's such a stressed organisation as a whole. And I think the only happy ones I see are the ones who feel safe, at least amongst their team. That, actually, I can raise a concern. And I won't pay for it, or be judged for it or... And people will listen,... And I can have a heated discussion with someone about a patient issue, and it will never become personal. It will remain at... And I think... I think unless we get to that level it's not a safe place because what... What if no-one challenges one another for what is happening? We all just walk past. You know, I wouldn't do that, ...So... I... I think trust is missing at the moment. I think everybody is self-protecting. And I think it's non-sustainable. I think we need to change that [implies mentoring] ". PF 1*

Several participants highlighted the use of mentoring skills and activities to enhance the wider medical community. This included supporting and developing the next generation of clinicians and developing connections across established communities of practice, facilitating the development of wider supportive networks.

*"working with, you know, a lot of medical students to, sort of... I'm supervising a lot of projects and they might ask for advice on how to approach issues. And I might use some of the mentoring skills there. Very much asking, you know, what's the most important thing for them in their lives. And trying to do things that, you know... Ask them to think of things that way." PA 3*

*"It's [mentoring] a two-way process. Also it forms a network. So one is a XXX surgeon, one is a XXXist – I've got a network of people, two people, who I can go back and seek help if I need it. Clinical help. I can go and talk to them. So... They may not be able to help me directly, but I can explore it. They can guide me. They can give me the direction." PL 1*

## Extending out to the wider community of patients

Significantly, several of the participants suggested the benefits of mentoring diffused across all aspects of the community of practice including enhancing care received by patients. Participants described being able to utilise mentoring skills to benefit patient care, particularly in relation to the application of effective communication skills, to enhance patient assessment and interaction.

*“So I think that’s been useful. And then, as I say, just, you know, with kind of the communication skills – there’s a refresher on good communication skills with the active listening – which has probably been beneficial, kind of, clinically, in terms of, you know, listening to patient histories, for instance. And explanations to... To families and things. I think that’s... It was just a good refresher. It has been a long time since I’d had any, kind of, communication skills.” PG 1*

*“I experienced that [feeling of not being listened to], first hand. The, sort of, need to shout and say, “Just listen to me.” You know, nobody is listening to me. And having... Having experienced it first hand, I [also now after learning about mentoring] listen to patients differently”.PF*

Such sensitive communication skills were considered by participant L to be particularly useful when dealing with complex and highly emotive aspects of care delivery including breaking bad news and palliative care.

*“That’s right – the skills. And this comes in handy when you deal with patients. Particularly if you say that you have to take the confidence from the patient to make the decisions. Particularly when they’re terminally ill or particularly when they are in their worst state of disease. Okay? And you have to help them to understand their situation, without being prescriptive that you’re dying. Okay? And I think that kind of skills, which you learn by interacting with these things – it comes in handy that you give that pause. You know, we say the pause speaks itself. With no sound. And that I picked up from mentoring the things. But I apply it more in patient situations now.” PL 2*

The data suggests the application of mentoring skills can focus the care interaction, utilising questioning and listening rather than advice-giving skills. This provides the opportunity for meaningful patient engagement which may ultimately result in more patient centred, individualised care.

*“I probably do use them actually a lot of the time in clinic as well. When I’m discussing treatment options with patients, you know. So I think you do use those skills. You know, I think it maybe gives you a tendency to be more patient-focused and perhaps explore... Explore what a patient’s wants and needs are. And then target your interventions to that, you know.” PA 3*

The fourth and final theme emerging from the data provided insight into participants’ perceptions of their workplace communities and culture, which they considered were unsupportive. However, the data suggested mentoring could mediate such unsupportive contexts, enhancing the culture, community and ultimately patient care. The following vignette drawn from a number of participant accounts illustrates the ways in which mentorship supports better working communities and cultures.

## Composite vignette of mentoring supporting better working communities and cultures

### *Experiences from a mentor in one unit*

#### *Context:*

This unit was in a hospital I sometimes work with, it was quite difficult environment to be working in, everyone was stressed, there didn't seem to be much support from one another and there is also a long-standing issue with bullying - therefore the unit was in a lot of trouble!

Compounding it all there had also been a challenging time with trainees. Some felt there were some struggling trainees who were then blaming the unit for all their problems. It almost felt like everyone was in self-preservation mode and some of the relationships between staff were strained to say the least.

One particular trainee came to me, they had lots of previous experience and lots of people saying they were very good and very capable. But in that unit, there had been some awful clinics where the mentee perceived more senior colleagues made him/her look really rubbish—the mentee was trying to fit in but felt overburdened, very aggrieved and angry.

#### *What the mentoring process did :*

We met several times over 6 or 7 months and communicated a lot in between. The mentoring allowed the trainee to step outside of some of the circular arguments - "You're a crap trainee", "Well, you're crap teachers and I'm overloaded ". Through the mentoring I tried to steer him/her to think through some approaches to communication, clinics and workload - actions they might want to take forward, just to think through some approaches and come in with plans. They were suddenly keen to come back for another session!

#### *Impact/outcome:*

I think it did make him/her feel supported and have a little bit more resilience. I think it gave a bit of space that was needed, allowed them to trust someone and feel listened to. It also enabled more positive viewpoint on where to do things and to look at strategies to deal with competing demands. Perhaps that little bit of time and head space meant that he/she got more out of the remaining time in that unit than he/she would have otherwise, helped to get a plan to get the best out of the situation.

Knowing where you're going in your training and career allows you to come out of that type of situation and not allow it to influence the next day and the day after and the day after.

I've heard since that the person is still in this specialty and doing well, doing fine. And when my name was mentioned they were kind about me. So that'll do me.

#### *Using mentoring in everyday situations*

I have also tried to use my mentoring skills more generally – in corridor conversations and meetings. Trying to listen more when colleagues might snap at each other - or when I felt like snapping at them!

I became aware that there were a range of 'habits' in this team –self-preservation, dumping on one

another and it generally felt like everyone had their back against the wall and no-one trusted anyone else! This feeling was evident in an experience with one colleague.

I became aware of a colleague who seemed particularly stressed as I chatted to him in the corridor- he was juggling home and work, ran a very pressured service which was needing to make cuts, and also had family issues which were impacting on work. It all seemed to be taking its toll and he was obviously struggling but initially very reticent about saying much – felt like he didn't want to say, or be seen, to be struggling.

He would never have come for anything badged 'mentoring', but over several corridor conversations I just tried to use bits of the model, to listen, get him to tell the story, to probe and then prompt him to explore strategies. After a few months there seemed to be a change, he would regularly pop into my office for a catch up. He told me about plans for a service reconfiguration which would alleviate some of the burden which currently fell on a small number of staff – including him, and of a holiday he had planned.

It felt as if he had turned a corner and perhaps using those mentoring skills and parts of the mentoring framework had helped engender trust and a feeling of support.

## Discussion and final remarks

This study aimed to explore the relationship between engagement in mentoring activities and doctors' health and well-being. The BITC<sup>2</sup> model has acted as a heuristic framework and enabled integration of findings from the diverse study elements giving rise to a proposed model of mentoring as a vehicle for specialist support.

### *Overarching model:*

We propose that mentoring can act as a vehicle for better specialist support, which can:

- emerge as signposting and referral to specialist services, or
- when the mentoring relationship becomes in and of itself the targeted specialist support

In both of the above modalities, mentoring acts as the specialist support through provision of a safe emotional space in which a skilled mentor<sup>2</sup> facilitates the mentee to surface, review and explore facets of an issue<sup>3</sup> they are facing, and then empowers the 'mentee' to explore possibilities and deciding on how to handle the situation. The mentor's skills are in listening carefully to everything the mentee says, empathically challenging blind spots, helping the mentee to: develop a wider perspective about the matter in question, to set goals, develop strategies to achieve these and to decide on a plan of action. Learning about and practicing this type of mentoring seems to be a way of helping someone become better at helping themselves – potentially enhancing resilience at both a personal and community of practice<sup>4</sup> level.

It seems that such an emotionally safe space may be created to varying degrees during a dedicated 'mentoring session' or via the use of mentoring skills and techniques in ad hoc, everyday situations.

The integrated findings from this study suggest that it is through the specialist support offered during the use of mentoring that relationships are explored, examined, considered, developed, revisited and often enhanced. Through that support and the enactment of 'mentorship' – be it in formal mentoring meetings or via seepage of mentoring skills into use in everyday situations, and through the re-visioned and re-vamped relationships, professional and personal wellbeing can be enhanced. Relationships lie at the heart of everything we do and are both as doctors and as humans. While health and wellbeing issues may emerge independent of relationships- we need relationships to 'deal with' those manifestations, thus perhaps better relationships may lead to better wellbeing. It can also be posited, that through this better wellbeing and the forging of enhanced relationships (be it with colleagues, people outside of work, or whoever) we can arrive at more supportive communities, cultures and 'better work'.

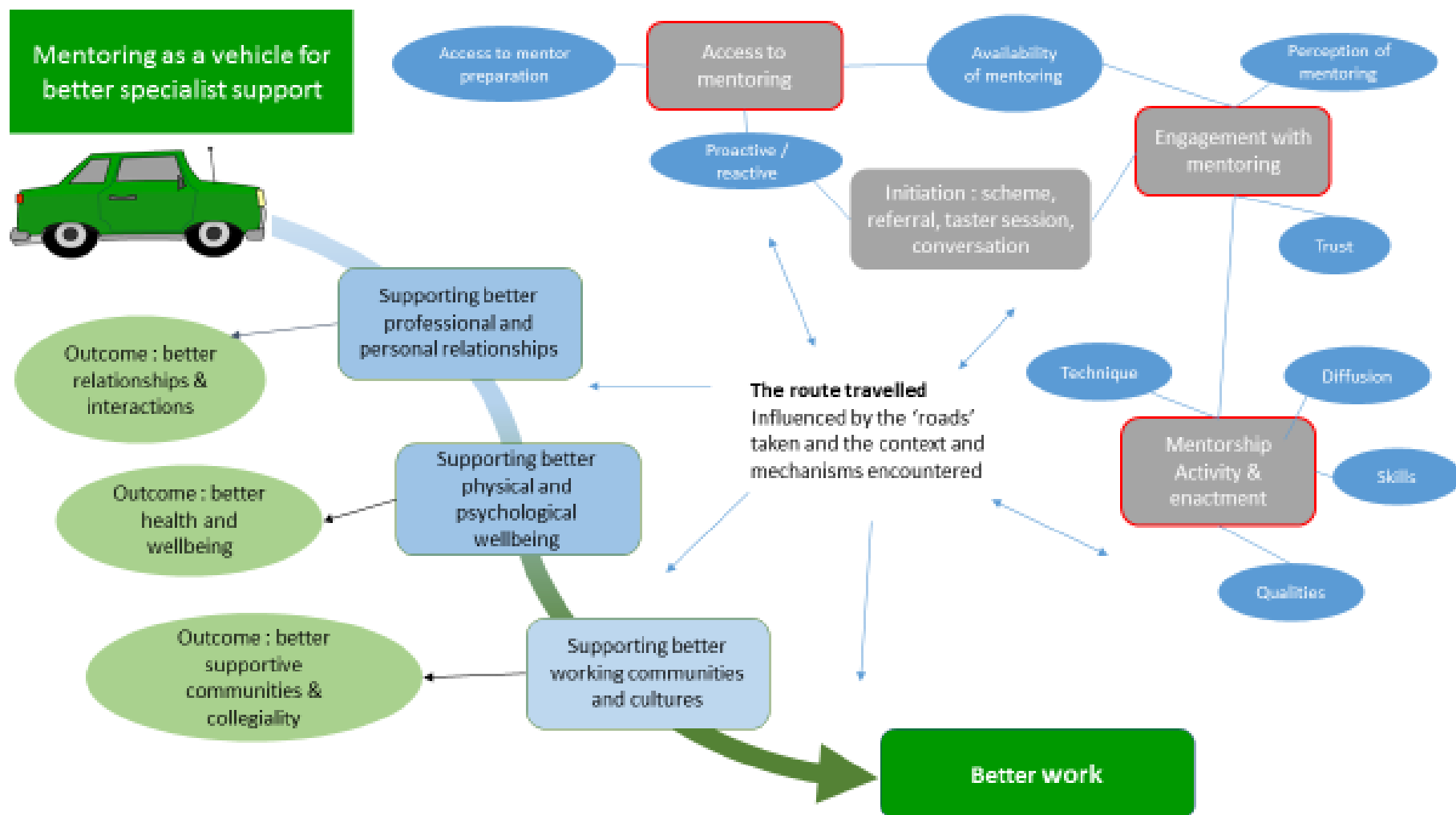
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<sup>2</sup> who has learned particular mentoring techniques and models - in this research that was predominantly the Egan Skilled helper model

<sup>3</sup> Which can be a dilemma, problem or opportunity

<sup>4</sup> Such communities of practice may be amongst groups of doctors or related to a ward, unit or Multi-disciplinary team

Figure 14: Mentoring as a vehicle for better specialist support



## Key issues

Integration of the various elements of this study point to several key issues as outlined in the following sections. These issues emerge as factors (contextual and mechanistic) which impinge on the potential of mentoring becoming a vehicle for specialist support.

## Availability and access

It appears that before mentoring can become a vehicle for specialist support there are the issues of 'access' which relate to,

- Interested individuals being able to access mentor development courses or programmes and
- Potential 'mentees'<sup>5</sup> being able to access individuals who have undergone mentor preparation or training.

Participants in both the questionnaire and the interview elements of the study commented on the potential negative influence of commonly held perceptions regarding mentoring. A received view of mentoring was described which positions mentoring as being for Drs with problems, in difficulty or failing. It was believed that these perceptions engendered reluctance to seek help or to engage in a formal mentoring process due to the stigma attached. Seeking help via mentoring was perceived as a sign of weakness, which could be damaging in an organisational and professional climate described by one interviewee as *'very much dog eat dog'*.

Furthermore both questionnaire and interview participants noted that a lack of understanding of what mentoring could entail or how it could be used in a variety of situations. This clearly raises questions regarding interpretations and understandings of two interlinked aspects,

- What mentoring 'is' or can be (i.e. how it is enacted, the models used ) and
- What mentoring can be used for (i.e. the purposes it can serve, the types of issue that can be addressed through mentoring).

Such a 'received view' may be further perpetuated by the language used around mentoring and be exacerbated by the lack of resources allocated to mentoring by professional bodies and/or organisations. Indeed questionnaire responses indicated a main factor limiting the presence and influence of mentoring schemes was a perceived lack of institutional or organisational support. This absence of support and 'value ' given to mentoring by the employer/institution or organisation manifested as a lack of allocated or protected time for mentoring and was also emphasised by the interviewees.

The values implicitly placed on mentoring by organisations (i.e. Indicated through the ways mentoring is used such as a device in complaint mediation, language used around mentoring, a lack of protected time, appropriate space or funding, limited prep/training course provision, limited or lack of mentoring schemes) may also influence (as contextual mechanisms) decisions regarding involvement as a mentor or mentee, and the ability to initiate and engage in mentoring activities. Thus availability, access and activity may be heavily influenced by perceptions in a complex relationship of inter-dependency, set in a harsh organisational and professional climate.

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<sup>5</sup> Or individuals facing issues or dilemmas who could benefit from 'mentorship' – i.e. the deployment of mentoring skills and techniques





## Mentoring activity

Findings from this study indicate once barriers to accessing mentoring are overcome, those who are engaged in mentoring suggest a wide range of mentoring activity is taking place and this activity, be it formal (through mentoring schemes) or informal (through personally arranged sessions or everyday ad hoc use of skills and techniques), is giving doctors additional ways of approaching and dealing with a wide variety of issues and opportunities.

Across the data collected mentoring skills and techniques were reported as being used with a wide range of people and for a wide range of reasons. These included use with trainees or supervisees, in appraisal, with the doctors in difficulty, with colleagues in everyday situations, with trainees at one-off taster sessions at professional meetings and also with patients and their families.

At the time of the questionnaire most (31) of the people who responded indicated currently being a mentor in a formally organised scheme, with almost as many reporting being involved in the informal mentoring relationship since completing their mentor training<sup>6</sup>. Additional evidence comes from the interviews within which we discerned approximately 69 examples of mentoring being used to deal with different topics over the 20 month period during which the interviews were undertaken.

Importantly almost all of the participants described using their mentoring skills and techniques outside of 'formal' mentoring sessions. They described using elements of the mentoring approach they had learned in communication and interaction with colleagues, conflict resolution, problem solving, and teamwork, including in clinical work with patients and families. Thus it seems the skills and techniques diffused out into many aspects of the 'mentors' everyday lives and this was perceived as very positive as it offered additional 'empowering' ways of approaching situations and relationships. It could be argued that this is a significant amount of activity, which is made all the more noteworthy when seen within the context of the threats to Drs Health and Wellbeing described and dealt with via mentoring (either formal sessions or skills and techniques use).

## Threats to DRs Health and Wellbeing

A wide range of issues, topics, dilemmas and situations were reported as being discussed or addressed via mentoring, all of which may be associated with potential impacts upon the health and wellbeing of doctors<sup>84,85</sup>. The majority of issues discussed in mentoring sessions derived from work related concerns. Career development, workload, work life balance and relationships were commonly cited work related issues raised at mentoring interactions. Although issues were infrequently articulated specifically as a physical or mental health concern, mentors frequently associated these work related issues to stress, morale, and managing in a crisis. For example, career development and career choices, or decisions, including promotions were frequently discussed. However, where a career decision or issue may have been the initial topic presented at a mentoring session, or raised in a conversation, once the mentor facilitated exploration of that topic the mentee

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<sup>6</sup> We acknowledge the need for caution in defining formal and informal and as multiple interpretations may exist.

often then identified other deeper issues to be surfaced and dealt with. So what may have initially seemed a simple topic actually was symptomatic of other deeper issues that a mentee needed to tackle, including workload, work life balance and relationship concerns. The data from the in-depth interviews helped to illuminate the potential interaction between work and personal life, with detailed accounts provided of situations related to workload or work life balance concerns, which impacted on the mentees personal health and well-being.

In addition the participants reported quite a high incidence of discussions involving factors that may potentially contribute to mental health concerns. These related to feelings of 'self deficit' such as guilt, feeling inadequate or lacking self-confidence. In several cases, these feelings of low confidence specifically coincided with a negative event. In addition, there was some instances of mentoring interactions dealing with an injury or negative thoughts or suicidal ideation.

Across both the questionnaires and the interviews, relationships emerged as the main issue dealt with in mentoring. Participants reported relationships with colleagues as the issue most often discussed, followed by bullying or harassment. Interviewees also frequently described issues being brought to mentoring sessions, which directly related to professional or collegial relationships in the workplace. Many issues related to day-to-day interactions often around training and education, service configuration, team dynamics etc. However some notable cases were linked to disciplinary procedures and others which are best described as the most severe issues/cases concerned situations related to bullying (sometimes across several levels: individual, horizontal and organisational). However, without breaking confidentiality and in order to maintain anonymity we have been careful in the reporting of these infrequent but significant cases.

### **Mentoring enhancing professional and personal wellbeing**

Participants perceived mentoring as very positively influencing the health and well-being of mentors and mentees. It is interesting to note that questionnaire respondents reported health and well-being outcomes as only slightly more positive for the mentees –implying important benefits for all involved, including mentors.

The interviews tracked and illustrated the ways in which mentoring skills and techniques assisted mentees and mentors to deal with situations and dilemmas - some of which had the potential to be extremely detrimental to the health and well-being of those involved. At the extreme there were descriptions of 'mentees' becoming extremely emotional in mentoring sessions (both in one off sessions or on-going mentoring relationships) and surfacing powerful underlying health and wellbeing issues. Mentoring assisted them in finding ways of dealing with these issues, either through referral to specialist support, or via the mentoring process itself, which supported them to explore, review, re-frame, and plan ways of dealing with the issues or situations.

Mentoring seemed to facilitate and prompt a review and reappraisal of interactions and relationships, assisting in conflict resolution, giving people the chance to 'step out' and find ways of re-framing or responding and dealing with the relationship issues. Thus mentoring facilitated a safe situation in which the mentee felt listened to and heard, and where they could explore achievable plans and potential ways forward- this seemed to engender greater individual resilience with some seeing the mentoring as almost a 'life saver'. Other instances seemed to be tackling issues which on

the surface may appear minor (such as prioritising work and work-life balance), but which were having a detrimental effect often both on the individual and people around them. Again mentoring often assisted the 'mentee' in prioritising and developing achievable goals – perhaps giving them agency and in some ways developing individual resilience.

For the mentors, application of the skills and techniques seemed to enhance communication and change interactions across a range of situations. While personal relationships were occasionally mentioned, mentoring seemed to have the most frequent and most positive influence on working relationships with colleagues. A noticeable impact for mentors related to personal morale and it was evident that participants derived satisfaction from their involvement, sometimes expressing feelings of being able to give something back or offer something to subsequent generations of Doctors. This sense of 'generativity', legacy and sometimes altruism indicated a sense of personal reward which could be construed as promoting the wellbeing of the mentors.

However, there were also some mentions of the risks involved, for example in the questionnaire responses one participant noted that a lack of follow up once mentoring had finished could have a negative effect on the mentor. In addition, there was a striking case during the interviews of a troubled and stressed mentee 'disappearing' for several months which left the mentor extremely anxious, but which thankfully resolved when the mentees presence became known again. Although these incidences were limited they do illustrate how there can also be negative impacts for a mentors health and wellbeing. In addition respondents also described added time pressures placed on them due to their involvement in mentoring. This can perhaps be seen as linked to a lack of institutional support and the creation of an environment in which mentoring is provided only by those who are able to fit it in or are willing to do it in their own time. Thus, the lack of organisational support for mentoring could be posited as also having the potential for an unintended negative impact on the mentors. This may however be counterbalanced by the sense of personal satisfaction gained and some sense of 'giving something back' to the professional community. Indeed despite the potential negative impacts questionnaire respondents reported many positive health and wellbeing impacts for them of being involved, these included greater skills, changed thinking and learning ways to deal with their own issues

### **Mentoring promoting healthier workplace communities**

The participants identified and discussed their existing practice communities and culture, and suggested mentoring could mediate unsupportive contexts and / or enhance the workplace culture, community and ultimately patient care.

Many of the participants in both the questionnaire and interview elements of the study described their existing practice communities and culture as largely unsupportive, with some participants perceiving there was limited sense of community. Such an unsupportive workplace appeared to foster a need for quick responses and a focus on self-preservation, at the cost of open, collegial working relationships and practices. Participants suggested that mentoring could act as a mechanism to mitigate the effects of such an unsupportive workplace culture. It assisted mentees in understanding and situating themselves within the workplace culture and to re-frame their position within the community of practice and reflect on the ways in which they and other individuals within

the community responded to and dealt with organisational pressures and work life balance challenges. Access to mentoring activities also helped individuals manage competing priorities impinging upon their work life balance by developing insights as to the key issues and creating a plan of action.

In addition, the participants highlighted how engagement in mentoring could mediate and improve the workplace context, by providing the opportunity for trust to be facilitated via mentees being listened to and respected in a confidential situation, creating a supportive environment away from everyday working. This promoted a sense of cohesion, which enhanced individuals' feeling of belonging to, and being valued as part of the community. The implications are that the use of mentoring (sessions or skills) provided these conditions and supportive context, which contributed to mentees feeling generally more positive about themselves and the workplace. Furthermore, a cohesive community of practice may foster a trusting and emotionally 'safe' practice context. Feeling safe within the community can enable participants to raise concerns, ultimately benefitting organisational function including patient care, by creating and enhancing social capital. Social capital involves the relational resources embedded in and emerging from relationships, which are important for enhancing collaboration and working towards the common good<sup>86,87</sup>. The development of social capital is associated with trusting relationships, reciprocity and recognition<sup>88</sup> and is viewed as important for job satisfaction<sup>87,89</sup> creation of safer care<sup>89,90</sup> and successful professional engagement in clinical improvements<sup>87</sup>.

Significantly, participants also suggested that the beneficial impact of mentoring diffused across all aspects of practice including into patient care. Some reported changed ways of interacting with patients, some posited there was a greater individual patient focus brought about by mentoring skills and techniques, especially in relation to enhanced communication and the provision of meaningful patient focused interaction. This suggests that the skills, techniques and models learned may prompt or enable Drs to adopt a different approach to patient interaction, perhaps less directive and more open to listening and empowering. Thus, in many cases these mentoring skills and techniques diffused out across the professional /personal everyday lives of the Drs involved in the study.

## **Contexts, Mechanisms and outcomes- beginning to conceptualise the relationships**

This study has identified some of the contextual factors, mechanisms and outcomes involved in mentoring activities. Prior to mentoring taking place there appears to be a complex, somewhat interdependent relationship between perceptions of mentoring, availability, and access- all of which has repercussions on subsequent mentoring activity.

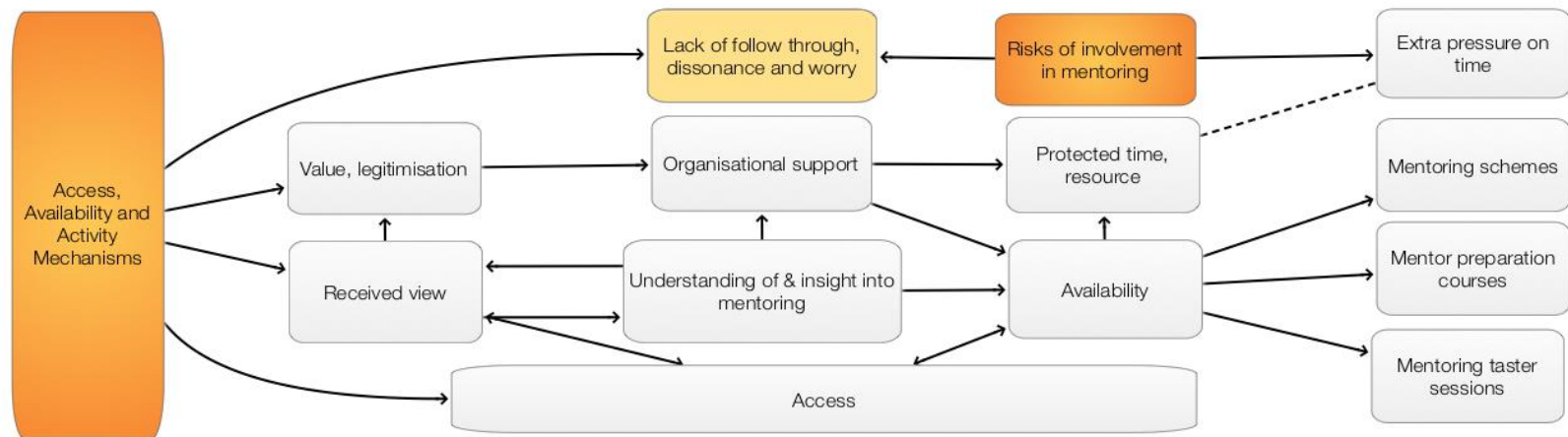
However once the risks of mentoring are ameliorated and activity is established this appears to have a range of benefits (or outcomes) both for those immediately involved and those more peripherally implicated.

The enactment of mentoring takes many forms including via formal series of meetings (as often described in the tracking of Drs element of the study), or via one of meetings (taster sessions at conferences) or indeed via the ad hoc informal use of mentoring skills and techniques in everyday situations (as described by nearly all of the participants in this study). While data analysis identified some risks (e.g. lack of follow thorough dissonance and worry for mentors) a multitude of potential benefits emerge for those involved. We posit that for both the mentor and mentee there can be a feeling of empowerment from the 'other centred' approach used in this specific type of mentoring.

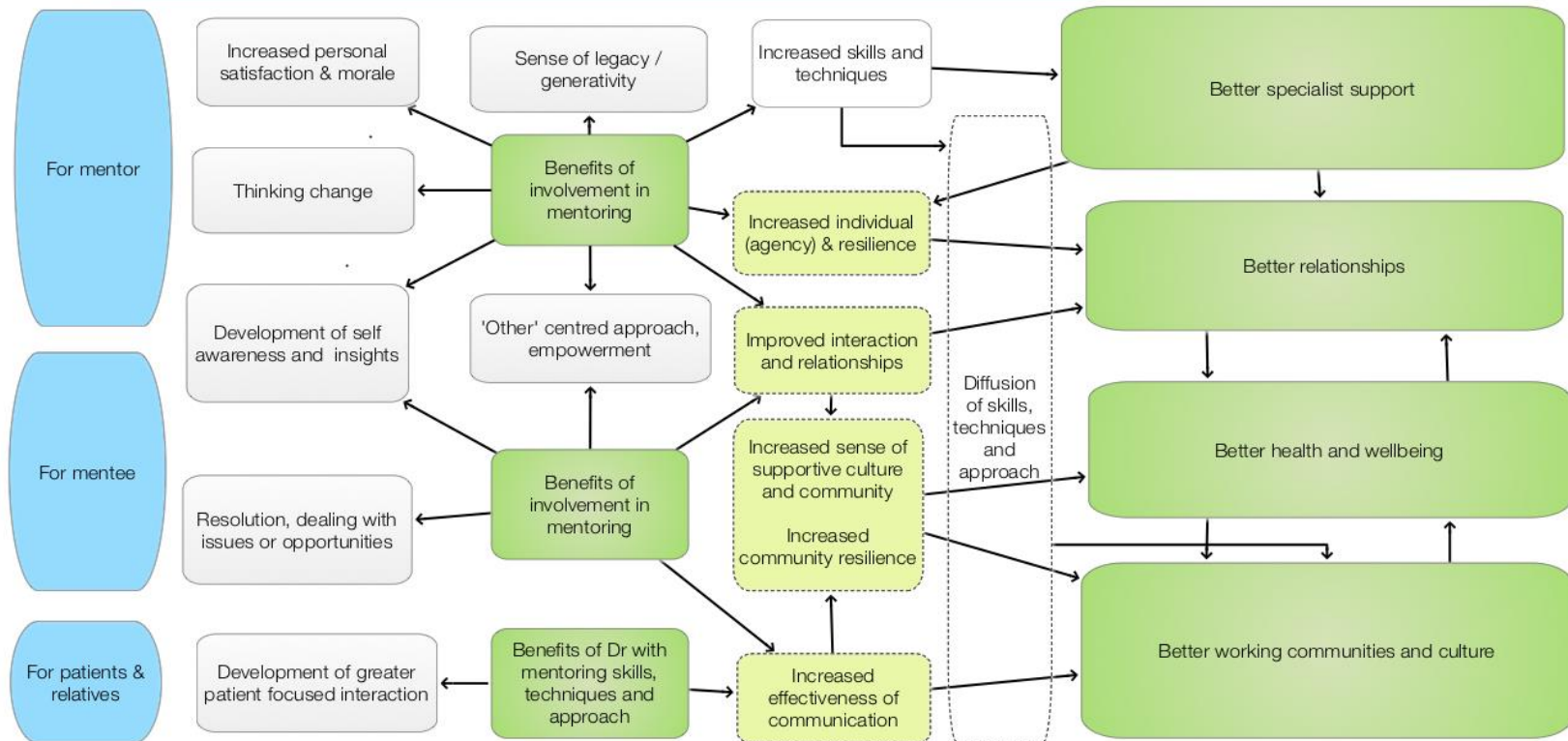
For mentors learning about mentoring gives them a range of skills and frameworks that they can use in a variety of situations (including self-mentoring and ad hoc everyday use) this can engender a thinking change and offer new ways of approaching situations. Mentors gain satisfaction, increased morale and a greater sense of collegiality and generativity towards their colleagues and other generations of doctors. We suggest increased 'agency', social capital and individual resilience ensues- with positive impacts for the individual's own health and wellbeing.

Likewise for mentees, engaging in mentoring via this 'other centred' approach seems to empower them, by acting as a specialist support mechanism and sometimes assisting in the development of self-awareness and insights. It offers a safe space to review situations, surface underpinning issues, try out different viewpoints and plan achievable steps towards resolution. Again we suggest increased 'agency', social capital and individual resilience ensues- ultimately positively impacting on the individual's health and wellbeing.

The resulting enhancement of interaction and relationships – be it with patients and their families, colleagues or within the Drs own personal lives has a range of benefits. We propose that this may facilitate greater resilience within communities of practice and prompt more supportive working communities and cultures. Thus mentoring can act as a vehicle for specialist support, enhances relationships and health and wellbeing - and ultimately facilitates supportive cultures and better work. The following diagram illustrates a conceptualisation of these 'factors' and some of the ways in which they interact.



### Mechanisms and outcomes of involvement





## Final remarks

To enhance individuals' response to workplace stresses and pressures, and to improve well-being, the use of workplace support mechanisms is advocated<sup>6</sup>. The GMC<sup>24</sup> highlight the potential of mentoring for providing wide ranging support stating;

*'A mentor is someone who will provide you with guidance and confidential support. This can be wide-ranging, covering not just clinical work, but also professional relationships and career plans'*<sup>24</sup>

As this study indicates mentoring can be one such support mechanism.

Findings suggest that mentoring activities offer a range of health and well-being benefits to doctors- both mentors and mentees. Mentorship supported better professional and personal wellbeing by enabling and enhancing:

- the ability to respond to wellbeing threats;
- insight into issues influencing professional and/or personal wellbeing;
- constructive responses suggesting development of resilience strategies;
- role fulfilment and satisfaction.

Only a few examples of negative impacts for mentors were reported.

Additional rigorous, systematic research and evaluation regarding mentoring could further develop our understanding of what works, for whom, and in what circumstances. Specifically in relation to the ways in which mentoring influences the health and well-being not only of doctors, but also of their colleagues and patients.

The data in this study suggests that mentoring encourages reframing issues and helping challenge established ways of thinking and to think afresh. From the examples given, this has led to reported behaviour changes through changing mindsets. One wonders if going from the very focused questioning needed to work quickly and efficiently clinically, the mentees are relearning the exploratory skills perhaps encountered in their undergraduate studies. The reintroduction of these skills and new models and frameworks perhaps allows the clinician to re-examine their practices. The reframing may permit time to decentre the problem but also establishes a sense of collegiality through having a fellow clinician who is approachable, empathetic and non-judgmental – traits that may be good for establishing positive role models within a culture.

The availability of positive relationships and social support is also linked to resilience; the ability of an individual to cope well despite adversity. Resilient individuals demonstrate characteristics such as the ability to reintegrate or rebound following an adversity incident, be flexible and have high-levels of self-determination<sup>7</sup>. Mentoring is thought to foster such characteristics through assisting doctors, as mentors and mentees to deal with a range of opportunities, dilemmas and issues, and teaching them a range of skills and knowledge they can apply in a variety of situations<sup>27, 32-35</sup>. Indeed this study adds further evidence to that proposition and indicates that mentoring can act as a vehicle for specialist support, ultimately often leading to better health and wellbeing.



At time of austerity, increased threats to individuals health and wellbeing and the concern expressed that mentoring schemes may to be disappearing due to funding issues or be being restricted to those with 'difficulties or failing' (thus perpetuating the negative received view already mentoring see ) we propose that mentoring should be given more space and resource.

That additional availability of mentor preparation programmes and mentoring schemes could, via the series of mechanisms described and favourable contexts, assist in the development of supportive cultures, better health and wellbeing and better work.

### ***Study Limitations***

There are several limitations to this study which need to be acknowledged. The majority of the participants volunteered to take part, the numbers involved are small, therefore the sample is not representative of the wider medical population in the UK and care must be taken when extrapolating from the findings as they are not 'generalizable' in a statistical sense . As with any voluntary sample the participants are self-selecting and may for the most represent those with a particular interest in mentoring and may therefore be viewed by some as being 'skewed'.

However given mentoring, unlike a medication or other 'physical' intervention, is not an activity or 'intervention' that can be imposed upon those who are not interested, curious or open minded about it. In essence (perhaps like some psycho-social interventions) it needs a certain amount of 'buy-in' to work. Furthermore it could be argued that the type of mentoring which predominated in this study (i.e. based upon an 'empowerment' or 'other' focused model such as the Egan model) is very different to the classical diagnostic/management orientation of medical thinking and thus attracts certain types of people. Therefore perhaps the best way to understand this particular phenomenon ('other' focused mentoring) is by researching those who practice it.

As indicated by the findings such 'selectivity' does not lessen the impact for those individuals involved and beyond. Arguably the use of elements of mentoring and the diffusion of skills, techniques and approaches into the 'everyday', may be seen as a broader impact which goes beyond 'mentoring' in the ambit of a one to one mentoring session.

However we also acknowledge that this may add limitations to the transferability of findings, although the range of specialities, geographical locations and length of time in clinical practice would seem to suggest that this type of mentoring, and the related skills diffusion, may have purchase and benefits across a broad spectrum of medical practice.

This multi-method study by its very nature aimed to explore and assess mentors experiences and perceptions of health and wellbeing impact via their subjective accounts. We acknowledge no independent objective measurement of health and wellbeing impacts were made. Indeed to attach such objective measures would imply both an objective definition of the fuzzy and somewhat subjective concept of health and wellbeing<sup>2,6,9</sup> and a large causal assumption - without the identification and tracking of possible mechanisms at play offered by this study.

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## Appendices

### *Ethics approvals*

*Vice-Chancellor and Chief Executive* Professor Andrew Wathey Northumbria University is the trading name of the University of Northumbria at Newcastle

***Professor Kathleen McCourt CBE FRCN***

***Executive Dean***

**This matter is being dealt with by:**

Professor Pauline Pearson

Ethics Lead

Department of Healthcare

Faculty of Health and Life Sciences

Coach Lane Campus

Newcastle upon Tyne

NE7 7XA

Tel: 0191 2156472

Email: [pauline.pearson@northumbria.ac.uk](mailto:pauline.pearson@northumbria.ac.uk)

17th December 2014

Dear Alison

**Faculty of Health and Life Sciences Research Ethics Review DHCSteven171014**

**Title: Exploring The Relationship Between Engagement In Mentoring Activities And Doctors' health and well-being**

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link: <http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard>

All researchers must also notify this office of the following:

- ☐ Commencement of the study;
- ☐ Actual completion date of the study;
- ☐ Any significant changes to the study design;
- ☐ Any incidents which have an adverse effect on participants, researchers or study outcomes;
- ☐ Any suspension or abandonment of the study;
- ☐ All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- ☐ All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely



Professor Pauline Pearson  
Ethics Lead for Healthcare, on behalf of the Faculty Research Ethics Review Panel

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**HRA approval**

**Email dated : 7/7/2015**

***Email correspondence***

Hello Alison,

Apologies for not coming back sooner. I have been checking this with a colleague.

As you are not recruiting via the NHS or using NHS services we cannot see why you would need HRA Approval or NHS Permission. Do you agree?

I hope this helps.

Many thanks,  
Mark

Mark Ryan-Daly | Project Lead – HRA Assessment  
E: [mark.ryandaly@nhs.net](mailto:mark.ryandaly@nhs.net) | M: 07917 555319

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**From:** Alison Steven [<mailto:alison.steven@northumbria.ac.uk>]  
**Sent:** 03 July 2015 09:53  
**To:** Ryan-Daly Mark (HEALTH RESEARCH AUTHORITY)  
**Subject:** RE: seeking advice on whether to apply for HRA approval

Dear Mark

I am very conscious that you will be extremely busy however I wondered if you were able to offer an opinion yet on the study outlined below and in the documents sent previously  
Many thanks

Alison Steven

**From:** Alison Steven  
**Sent:** 25 June 2015 16:19  
**To:** 'Ryan-Daly Mark (HEALTH RESEARCH AUTHORITY)'  
**Subject:** RE: seeking advice on whether to apply for HRA approval

Hi Mark

Drs will be identified via existing mentoring networks including organisations providing training ( e.g. AAGBI, Dr Redfern, co-applicant, has established links with training providers). Dr Redfern and any other link people distribute the information and the Drs then opt in by contacting me – therefore I have no access to their details unless they get in touch with me and they are not (to my knowledge) identified via NHS trust records

Hope that clarifies things- happy to answer any other queries

Alison

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**From:** Ryan-Daly Mark (HEALTH RESEARCH AUTHORITY) [<mailto:mark.ryandaly@nhs.net>]

**Sent:** 25 June 2015 12:30

**To:** Alison Steven

**Subject:** RE: seeking advice on whether to apply for HRA approval

Hello Alison,

Thank you for contacting us about HRA Approval.

Before I reply with an answer, please can you let me know how you will be identifying Drs?

Many thanks,  
Mark

Mark Ryan-Daly | Project Lead – HRA Assessment

E: [mark.ryandaly@nhs.net](mailto:mark.ryandaly@nhs.net) | M: 07917 555319

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**From:** Alison Steven [<mailto:alison.steven@northumbria.ac.uk>]

**Sent:** 25 June 2015 12:04

**To:** approval hra (HEALTH RESEARCH AUTHORITY)

**Subject:** seeking advice on whether to apply for HRA approval

Hi

I have been funded by the BMA for a small study which explores the perceived relationships between doctors involvement in mentoring activities and health and well-being.

It does not ‘measure’ health and well-being but gathers self-reports of mentoring activities and perceived links to Drs’ health and well-being (in a very broad sense).

It is a qualitative study and has been approved by the university ethics committee (see letter attached) – given it only involves staff by virtue of their role as a Dr and that all data collection will take place out with NHS property/sites it has not been subjected to IRAS.

I am unsure of the position of the study in relation to HRA/ R&D type approvals and would be grateful for advice

Many thanks

Alison Steven

***Dr Alison Steven PhD, MSc, PGCRM, BSc(Hons), RN, FHEA  
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### ***Dissemination***

Wilson G, Larkin V, Redfern N, Stewart J, Steven A. (2017) Exploring the relationship between mentoring and doctors' health and wellbeing: a narrative review. *Journal of the Royal Society of Medicine* 2017; 110: 192–201 DOI: 10.1177/0141076817700848

Steven A. Mentoring Activities and the relationship with Drs Health and Wellbeing: results from a 3 phase BMA funded national study. (2018) Academic Association of Anaesthetists of Great Britain and Northern Ireland, Royal college of Anaesthetists, Keynote: London

Steven A (2018) Royal College of Emergency Medicine (2018 May) Mentoring and Drs health and Wellbeing: Exploring the relationships. 'Flourishing in Adversity' event RCEM London

Steven A, Stewart J Larkin V (2017) The challenges of evidencing education and support interventions such as mentoring. 8th International Conference of Evidence Based Healthcare Teachers & Developers 25-28 October Taormina, Sicily

Steven A. (2017) Mentoring research: Lessons for the AAGBI. Academic Association of Anaesthetists of Great Britain and Northern Ireland, Royal college of Anaesthetists, London September 14th

Steven A (2016) Re-imagining Healthcare: Egan mentoring and the changed medical mind set. International Qualitative Health Research conference.(Abstracts Published in International Journal of Qualitative Methods) Kelowna Canada October 2016