THE
ELIZABETH BRYAN
FOUNDATION TRUST
Care, Concern, Compassion

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CARING FOR THE CARERS
Mentorship for those in the Caring Professions

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I am pleased to be here today giving this lecture as Chair of The Elizabeth Bryan Foundation. The Watchwords of the Foundation: *Care, Concern, Compassion*, form the basis of mentoring as I see it. This lecture will address all of these as well as adding three more C's to the banner, namely *Confidentiality, Choice* and *Closure*.

Informally, of course, since I have no intention of turning a personal journey through mentoring into a textbook lecture. Nor am I an accredited researcher on the subject. I am indebted to a friend, fellow RCN Fellow and colleague Paula Hancock for her advice in preparing this paper and for sharing her thoughts with me

I apologise to those of you who are not nurses for beginning with nursing, for returning to nursing during the next 40 minutes, and perhaps even for ending with the profession dear to my heart.

Mentorship means different things to different people. It is a term that sometime confuses, especially health care students, some of whom are first introduced to mentorship whilst on clinical placement. I have mentored for many years, occasionally formally, when I have been asked to mentor one or two students on a course. *The Department of Health Leadership* courses aimed at helping women challenge the "glass ceiling" come to mind as well as the work done with the *Beacon Organisational Development*, the Executive Director of this innovative foundation is especially welcome here tonight, which concentrates on developing leadership skills in black and ethnic minority healthcare employees. *The Royal College of Nursing* too runs a variety of programmes addressing clinical leadership as well as professional growth.

More often I am asked through contacts to "see someone", often someone who is not "fitting in", "conforming", or who has a personal ambition that "does not quite fit"

When I meet a new mentee, neither of us have any idea how the relationship will develop, so the first challenge is to ensure we both understand what we mean by mentoring. The next is to agree our contract, informal of course, and how, when and where we will communicate. We need to affirm a joint commitment to the journey we

are beginning, and we both need to recognise the relationship will end. We both have expectations but not firm directions. It's a learning experience for both of us and each experience is different.

The definitions of a mentor are many, but can perhaps be summated as "wise and trusted advisor." The mentor must be chosen by the person seeking mentorship and agreed to by the person they are seeking mentorship support from. In other words an arrangement freely entered into by both parties, seldom bound by anything other than mutual consent.

True mentorship is rarely time limited. It is non-judgemental and the information shared is held as privileged with permission being sought if knowledge gained through the relationship is to be shared, perhaps as part of a reference.

Just over 30 years ago The Royal College of Nursing supported a Commission on Nursing Education. Funded and hosted by the College it was chaired by Professor Harry Judge, Director of Educational Studies at Oxford University, and included an equal number of nurses and non-nurses. The commission explored, not for the first time, the way non-nurses and midwives were educated in universities and training schools and made many recommendations which informed and influenced the move to student status, graduateness and the integration of our students and staff into higher education.

What concerns us today is their recommendation that those teaching students the theoretical content of the course should also teach them in practice:

And I quote:

"all types of respondents were, on balance, in favour of teachers of nursing carrying clinical responsibility, health authorities being very positive on this point"

There were over 100 respondents, most of whom were corporate organisations who consulted widely with their members about their contributions. Some commented on the integration of theory and practice in medical and dental schools in the UK, others on the teaching in the (very few) UK nursing schools based in a university, who had followed that same way of bridging the theory/practice gap, namely that lecturers worked with students in the wards helping them apply their theoretical knowledge in the direct care environment. It must be noted at this point only 400 students out of 22,000 admitted in 1984 to nursing courses were in a university programme.

Why this history?

Because it gives the background to the development of what was, in 1987, introduced as mentorship by the Nursing Statutory Body - when for me it clearly is not.

Many of the recommendations of the Commission were accepted and introduced in one form of another. What was never funded was the movement of lecturers into practice with their students.

So the then Statutory Body introduced something else, and for some reason called it mentorship, and confused entrants to health care professions at the start of their careers.

Mentorship for nursing students was introduced by The United Kingdom Central Council the 1987 curriculum with the vision that mentors would be nursing students' "trusted advisors" selected by the student to "assist, guide, befriend, advise and counsel" as they learned in clinical placement.

Nothing at variance with traditional mentorship there then!

But this vision did not last, in fact it never really started as envisaged. From the start mentorship was formalised by training clinical staff through programmes, by the UKCC at first, then by the universities, to ensure students had the same experience from their mentor - a "one size fits all" model, essential when the mentor assesses and can thus pass or fail a student. Failing, of course, sometimes lead to appeals, a very formalised university process. And far removed from the role envisaged in 1987 of "befriender, guide, counsellor"

For a qualified nurse being a mentor is "a plus" when applying for promotion.

The student, on arrival at the placement, is allocated a mentor, who will support them whilst in the placement.

So far no *choice.*

One hopes the mentor offers the student *care* and *compassion* and has *concern* for the student's clinical experience.

But since the mentor is responsible for assessing the students clinical competence *confidentiality* often flies "out of the window". The student's work will be discussed with other health professionals, especially nurses, before being graded and sent to the university tutors where it will be filed, to be brought out at examination boards and for reference writing. A student who fails will have to be reassessed, often by the same mentor.

No problem with *closure.* This mentorship will end abruptly as the placements ends Assessment by mentors is so closely tied to their success on the course - remember nursing and midwifery students undertake 4,600 hours of teaching and learning in their three years, and 2,300 hours of this are in the clinical setting - passing clinical practice is compulsory.

And only this month we have evidence from Birmingham City University that some mentors are being subjected to bullying and threats by students. A recently published study, reported in Nursing Standard on 21 September this year found that "*after receiving negative feedback, some students use manipulative behaviour in an attempt no to fail*" Louise Hunt, the Senior Lecturer who undertook the study reported mentors receiving both verbal and physical threats including confrontation in a carpark by a student's boyfriend.

The concern with my profession's use of mentorship is shared by others, not least by the RCN, who in a 2005 report described mentors as the gatekeepers of students'

practice competences, most importantly judging the student's progress in the placement and formally reporting on it.

They too saw the mentor as examiner rather than as guide, friend, adviser and counsellor.

I have always seen the introduction of formal examining and assessing into the role as devaluing the true concept of mentoring, in that I believe mentorship has to be non-judgemental. I also believe that mentors have a duty of confidentiality and care to their mentees. The role of assessor/examiner does not, of course, diminish the duty of care but it must surely abolish the confidentiality and trust inherent in true mentorship.

What increasingly makes this approach to mentorship more difficult is the growing stresses on time for mentoring, privacy for the discussions, the fact that these meetings and discussions take place in the workplace means the demands of care have precedence. The difficulty of mentoring in the workplace is compounded by the total lack of privacy meaning any discussion is in constant possibility of interruption.

I understand the usual place for private conversations for nursing students is where it has always been - namely in the sluice.

Having shared with you my concerns about my profession's approach to mentorship and the confusion it causes when, as qualified practitioners someone is offered more usual mentorship as part of a programme of personal and professional development, I want to turn to my own personal journey

Having told you what for me it is not, I turn therefore to what for me it is:

I began training as a nurse in 1962, at Manchester Royal Infirmary. This was not my first choice of hospital training school, but nursing was what I always wanted to do, and I made that decision early enough to take GCE subjects that helped me secure a place at a teaching hospital - the elite training schools attached to hospitals that trained medical students.

My Vocation - an old fashioned word now but much used then, met two challenges. Both involved my father and my headmistress. The first was the conflict as I passed GCE high enough to enter sixth form. But future nurses "did not enter sixth form". They went as cadet nurses to the local hospital - and that was that.

But my parents were emphatic that I joined the other 19 out of 60 girls who formed lower sixth that year and that I prepared for A levels. So join I did, taking A levels alongside those preparing for Medical School.

Medical School was to become my second challenge. A few weeks into lower sixth I was "invited" to join my parents at a meeting, the first of several, with my headmistress. The objective of these meetings, which took place over a few months, was to convince me that I really wanted to do Medicine and to convince my parents that "an intelligent girl like me would be wasted in nursing"

I was later to discover that this pressurisation was a result of Government directives to medical schools to increase the number of women entering the profession. More

women were the answer to the growing need for family doctors and Physicians working in Public Health positions

Fortunately my parents were comfortable with my choice of career and I stayed as the ugly duckling in a group where everyone else was a swan aiming for University, or at the very least Teacher Training College.

This was the last I was to hear of Medical School - though not of the comment about intelligence being “wasted in nursing”

I was helped in my resolution by really knowing what I wanted to do and by two older nurses who were my first mentors. One had trained at a London Teaching Hospital in the 30’s, had married, left nursing of course, and eventually had a son. But post-war she had returned to nursing as an occupational health nurse in the mills in Halifax, and by the 1950”s was practising with considerable autonomy.

The second was our next door neighbour, again trained at a teaching hospital, this time in Dublin, and also practising with autonomy as a Queen’s Nurse.

Incidentally, much to my paternal grandmother’s regret (herself a retired midwife from Glasgow, who returned to practise when she was widowed) this neighbour was finally to convince me that midwifery was not for me when she completely overran any mentorship rules - had she known them - when she invited me to be present when her second child was born at home. That convinced me I did not want to be a midwife! Proving that mentors can facilitate negative as well as positive choices.

But without knowing the term both mentored me, encouraging me find a Teaching Hospital, since career prospects were so much wider…adverts for jobs frequently carried the term “Teaching Hospital trained preferred”….sharing their experiences, advising on application, preparation for interview etc. and they were to remain there for me when I went home during days off as a student, listening, supporting, encouraging….mentors before mentorship became fashionable

With their encouragement I was accepted at a London Teaching Hospital, only to regret this some months later when my maternal grandmother became seriously ill. I wrote to my future matron explaining I no longer wished to travel so far and she immediately responded by telling me she knew the Matrons at both Manchester and Leeds Teaching Hospitals (my first introduction to networking?) and was sure either of those would take me.

So Manchester it was with its past two Matrons leaving a legacy of service to their profession second to none. They were Military Matrons, RCN Presidents, and active participants in the development of the profession. MRI’s present Matron was just about to leave to take up a post at the London Hospital I had just turned down….Networking indeed . Now I knew why the Matron retiring at UCL knew the “shortly to take up post” Matron replacing her

MRI had many good points but Mentorship was not one of them, although I was to meet Networking again in 1966 when I went to tell my then Matron I was moving, with my soon-to-be husband, to Oxford, Cambridge or London and could I have a reference please. No need, said she, “I know the Matrons of the Teaching Hospitals Let me know where you will be and we can telephone them”

So much for the power of the Matron …and a Network

I was to spend two years in Oxford, then back to Manchester. By 1974, I had two sons and was working part time teaching students in the wards…a reasonably new role developed by the then General Nursing Council called a Clinical Teacher

Returning from holiday early in September 1974 I found a letter from Matron

Please attend my office at 9am on Monday morning. Do not go on duty first. My first interpretation of the type written letter was….you've guessed it… what Capital Offence had I committed before I went on holiday. But further reading saw she had used my Christian name and even put under her signature "This is not a disciplinary interview"

She offered me the hospital's place on the new Manchester University Nursing MSc starting that day and being taught in the Medical School. Fully funded for two years, job guaranteed at the end, nursery places for my children. Only possible of course because 14 years before my parents stubbornness in insisting I remained in 6th Form and completed A levels meant I could matriculate.

During my two years at University I was to have a Mentor. After our introductory week the 10 of us on the course were invited to make an appointment with a member of staff who would be our personal tutor. If after the initial interview either student or staff member felt another lecturer would be more appropriate change would happen.

Choice indeed

Throughout the next 18 months the two of us who shared this tutor were to develop total trust in her. Wise counsel, keeping confidences when needed, advising how to best share issues and with whom, concern about how address and handle challenges, she taught us, by example, not through a course, how to be a good mentor.

And then she left.

Neither of us bonded with her replacement and we sought tutoring support for our last few months with appropriate lecturers.

Our old tutor continued to mentor us from afar, encouraging, advising, helping us develop our careers and our professional lives. My colleague went on to Chair RCN Council, I to be its President.

CLOSURE happened gradually as she retired, although we were always in contact and I suppose in the end were professional friends

As I developed a career in teaching nursing I suspect I learned early mentoring skills as a personal tutor.

But 1981 was the year I really began to recognise the then growing interest in mentorship in the caring professions

In 1981 I was awarded a Regional Health Authority Scholarship to look at how nursing student's Clinical Competence was assessed in the EEC. The profession had signed up to European agreement on mutual recognition of qualification for Adult Nurses and the subject of Practical Competence was of interest to educators and Matrons. My ex University tutor had been invited to hold a workshop at a two day General Nursing Council conference aimed at informing their work on producing the first "Code of Professional conduct" for nurses.

As Mentors do, looking out for opportunities to develop mentees, she contacted me and asked me to contribute to her workshop exploring the ethical issues around assessing in practice. I suppose all that went well enough but I remember little of it

What I do remember was a presentation by Dr. Alastair Campbell, then Senior Lecturer in the Department of Christian Ethics and Practical Theology in the University of Edinburgh. Much of his lecture was to appear later in his book "Moderated Love: a theology of professional care" published in 1984 by SPCK and described by my mentor, in her review in Nursing Times as

"Starting from what every nurse knows, it sets out on an exciting voyage of moral and ethical discovery"

The book does all that.

But it gave me something different, namely a recognition that Caring Companionship could be a ground print for how I was to approach mentorship. Campbell takes as examples for development of his ideas the professions of Medicine, Nursing and Social Work and defines Moderated Love as a way of "skilled companionship" being practised through "being with" or "doing to" someone else.

Nursing had moved away from "doing to" with the 1977 curriculum which insisted the patient and his or her family and friends (significant others) should not only be involved in decision making about care but should be central to it. "Being with" fitted perfectly with this new way of care giving as well as his thoughts on companionship fitted with the new development of patient/nurse interaction being defined as "the patient journey"

It was not too difficult to transfer these concepts to a teacher/student relationship especially as that too has a clearly defined route to travel and a recognition that the journey has an end, in the case of a student (hopefully) Qualification and Registration, with a patient recovery or a peaceful death.

It was rare at the time for any healthcare or teaching journey to offer any choice about doctor, lecturer or clinical manager, although patients, students and staff usually managed to find someone within the care or teaching team in whom they could confide more intimate matters. As a ward sister one of my most valuable patient confidantes was my ward cleaner. A local woman, talking to local patients whilst mopping the floor, cleaning the locker, tidying away the food tray, she would often be told things they wouldn't share with more formal staff in white coats or uniform hats. She understood confidentiality, seeking their approval to pass something on…."Sister, Mrs Jones' daughter has just had a baby in the Maternity

Unit. She'd really like to go and see her" or when it was much more personal would say "Sister, have a word with Mrs Smith"

Confidentiality, Care, Concern, Compassion are concentrated within his model. Closure too, and he recognises closure is difficult for us all Sometimes Closure is planned, as with Discharge, the end of a course or placement, but sometimes, when in practice, it is sudden, especially with an unexpected death, or these days a rushed discharge that no one is prepared for

I began to approach mentorship using Campbell's Caring Companionship first as a personal tutor, ensuring students and staff for whom I was responsible were really able to choose their personal tutor. Sometimes this lead to overloading of one tutor, easily solved by removing their name from the list of available staff for a while.

Offering total freedom of choice can have interesting effects. Later in 1981 I attended a course organised for experienced teachers of nursing and midwifery. Course members were told they would not be allocated to the 4 tutorial groups but could sign up for the one they preferred. The content of the seminars were identical but 27 of the 31 members signed up for group 4

Why? No-one knew any of the staff beforehand.

The first three groups, led by the three experienced staff tutors were allocated one each of the 3 Seminar rooms on site. Seminar Group 4, led by the younger staff member, it was announced, would meet "Offsite" The attraction of seminars "in the Bar" was overwhelming

Popularity of a tutor group, like a mentor can depend on a variety of things totally outside professional competence of the leader!

But what was the effect on the three who were rejected?

We take great care as teachers when we fail students to find something in their work to praise. Encouragement is vital if they are to improve and progress On the rare occasions when I have decided I am not the best person for the mentee to have chosen it is usually possible to "soften" the expectation by using one's networks prior to the discussion to find someone much more suited and to whom one could refer.

But coping when you are rejected can hurt..as does all rejection. Like the three staff above, one wonders why

Am I too old?

Not published enough?

In the wrong place?

Some reasons hurt more than others…but meeting in a convivial place can certainly influence relaxation and an easy start to the conversation. However it is always wise to ask "are you happy to have me mentor you?" and if there is some dissembling as the adult in the relationship encourage them to verbalise that they would prefer

someone else. Have the courage to ask if you can help them find someone…then shake yourself and get on with life.

Before beginning on a mentorship journey it is as well to know the ground rules. For me, retired, I am usually free to arrange meetings to suit my mentee. This is not true if both are working.

And that begs the next question:

Is the time for mentorship within or out with working hours? If so, is there a quiet place where we can meet, bearing in mind I am a bit old to “do” sluices, sitting on the sink or leaning on the bedpan washer!

And the next question:

If an organisation is supporting the mentorship is there a minimum and maximum number of times the Organisation requires contact?

Or, how often does the mentee expect contact?

Is this contact face-to-face or can it be online?

There is a cost if travelling is involved?

Who is meeting the cost?

How do I and the mentee claim?

Does the Group/person responsible for the arrangement understand the ground rules of *confidentiality.* Also that if, at first meeting either of us decide the relationship will not work we are both free to exercise *choice* and walk away.

There are of course other questions that come to mind - I give but a few as examples.

Once both of us are comfortable with our informal contract I usually explain how I plan to work with them using a Caring Companionship model.

Campbell summarises it as:

“ a closeness that is not sexually stereotyped: it implies movement and change; it expresses mutuality; and it requires commitment within defined limits……it is not a deep, personal friendship but a bodily presence which accompanies another for a while. The good companion is someone who shares freely, but does not impose, allowing others to make their own journey which will terminate when the joint purpose which brings them together no longer obtains”

He goes on to say that the skill of companionship lies in sensing the needs of the other and accommodating as far as is reasonable, to those needs

It involves some “giving of self”

For me his framework has given me an approach to mentorship which served me well. I like to think it met the needs of those I mentored too Some reassurance comes, of course, from those who still contact me long after any formal commitment has ceased.

Sometimes with problems they wish to discuss….when I retired the Council of Deans acknowledged that retirement at their Annual Dinner. It is customary for someone to say a few words. The few words for me began with a fellow Dean, who I had mentored through a Glass Ceiling programme some years previously beginning with a poem she had written that started:

“Betty is my friend and mentor, many a problem I have sent her”

Hardly Wordsworth… but you get the drift

Sometimes it’s for Career advice, hopefully early in the move not after they have failed at “trial by sherry”. I may be sent a CV, or an article to proofread, I’ve been asked to weddings, spoken at a funeral and sat with a couple, one of whom I mentored on the DH Leadership programme, whilst their baby, who was 3 days old, died.
They wanted someone not emotionally involved to just “be there”

But back to the mentorship journey

As at any first meeting I find it important to avoid preconceptions. Purple hair, shaved heads, formal suits, dark clothing All bring their own statement to this first meeting.

I try as far as possible to let the prospective mentee choose where the first meeting should take place, and once introductions are over I try to ensure the ground rules are clear. I am not here to take the role of clinical supervisor, or to be their counsellor, nor am I an examiner or assessor, I will make no report of our meetings to anyone other than, if required, to confirm we have met. I rarely take notes, although I will write down an “action point” if I agree to do something.

Now he or she has met me they have freedom to say I am not what they want in a mentor, just as I am free to suggest I do not have the competences they need and they must seek elsewhere.

I explain the Journey we are embarking on, that it needs commitment from both of us, and, even at this early stage,
reminding them that mentorship is time limited.

I find it helpful to keep communication formal, I do not give out my home telephone number, nor my address, although I do share my mobile. I do not invite mentees into my home, i have never yet met at the home of a mentee, although I could see a situation where this might be necessary

The Journey itself brings the need for many skills, though not at a frightening level of expertise

Listening, and more important hearing and assimilating is vital, as are some counselling skills, especially those around advising, and suggesting choices without directing.

The ability to bring closure to a session, sometimes difficult to do, is a skill one needs to learn. Though as increasingly time is governed by parking charges or fixed time travel train fares this is becoming easier.

I have no fixed idea of how often one should meet together, but I do try to stay in online contact roughly every seven - ten days. I may have found an article I think they may find useful, a job that seems just what they are looking for, a conference I think they should consider attending/presenting at - after all a lot of mentorship is about career development, or I may be meeting a colleague who I think they would value meeting too. Another role of professional mentorship is encouraging networking, that mutual support that offers so much.

Which brings me to the end of the Journey - and to another book, introduced to me some 35 years ago by someone I would now call a mentor.

Jonathan Livingstone Seagull, by Richard Bach, is about a gull who wants to fly higher. Like many of those I have mentored on leadership programmes. He finds a mentor who tells him “you can go any place that you wish to go” The trick is to stop believing yourself limited in what you can do by convention

A long time ago I worked with an amazing theatre sister on a cardio thoracic unit at a time when invasive heart surgery was in its infancy. Although married she had no children and her husband was a sales man in the local branch of a chain store. She earned twice as much as him and carried many of the pair’s financial responsibilities. She was approached by another hospital offering more responsibility, a state of the art operating theatre, skilled surgeons and more money. She turned it down “Fred wouldn't like to move” Six months later Fred applied for a transfer to be near his sick mother. She gave her job up immediately and moved to a Community Hospital that had no theatres.

So much for convention.

Of course one real challenge, when mentorship is “voluntary” is to reach those who really need it. So often the ones who seek you out are those who have self-confidence, and who would no doubt have found their way through the clouds themselves. So often my role was to encourage them to step out, to take the plunge, to ask the question, to give a paper, publish a short article…. to have the courage to recognise and use their obvious knowledge and ability. All this widens horizons, helped by Royal Colleges and professional organisations who offer innumerable opportunities to network, and to develop professional knowledge through what the College calls forums and the Royal Society of medicine next door calls sections.

Reaching those who do not seek a mentor when one is offered is harder and as teachers, and indeed parents, grandparents, friends, we need to convince those we care for that asking for help is a strength, not a weakness and that by allowing someone to help you you give them something too, especially in making them feel valued.

I try to convince anyone I work with to consider if expectations, their own or others", are limiting their personal and/or professional growth and to explore ways of maintaining individualism, seeking to manage others expectations through concensus, rather than confrontation or mere "giving in".

Although we all are, in spirit, free to go where we wish, we may for the moment have responsibilities, often children or increasing older family. It is curious though how, in 2016, it is invariably the females who have "responsibilities" As far as I am aware it took two parents to create us and two of us to create our children.

"Responsibilities" belong to others as well as you. I try to enable anyone I mentor to develop skills of consensus and to use these skills to ensure that "responsibility" is shared

Convention shouldn't constrain individual growth, and mentorship can explore whys of working through expectations and developing despite responsibilities

When consensus doesn't work there are other "tricks" that can be used to reach one's goal. Arriving early at a meeting and sitting where you are best able to catch the eye of the Chair, moving the place cards so others who share your views are in his or her sight
(this has the added advantage of ensuring the Chair's allies are less clearly in view), and "keeping your powder dry" by not speaking early on an item but informing the Chair you do wish to listen to the debate but would like to say something at the end if it has not already been said. The opportunity to close a discussion often brings the opportunity to win the debate

Jonathan Livingstone Seagull learns to fly higher, and in time begins to encourage others.

As with all of us who teach, encourage and mentor, the time comes to end the Journey. Jonathan launches his pupil off the cliff, stands there watching him fly into the sunset uttering the words "No Limits"

And that is what mentorship should aim to do; encourage and support others on their own professional journey, a journey we join for a time, but which ends at the parting of the ways. During the journey we should have helped their personal and professional development, renewed their appreciation of confidentiality, enabled them to practice choice and decision making and grow as a person. We should have introduced them to networking, helped them look beyond convention and leave them with a wish to fly higher.

Like some seagulls they will return from time to time, whilst others fly into the sunset. Some will become known as specialists in their field, gaining fame and fortune; others will demonstrate the ability to become a change agent or a whistleblower. All, I hope, will use their strengths to improve patient care and their contribution to society as a whole.

For further information see:

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Royal College of Nursing. *Helping students get the best from their practice placements.* **www2.rcn.org.uk/__data/assets/pdf_file/0011/78545/001815.pdf**