Interprofessional mentoring – Exploration of support and professional development for newly qualified staff

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Abstract

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The aim of this study was to examine whether newly qualified healthcare staff can be supported in their journey to become a practitioner using an interprofessional framework to mentoring. The study involved the mentoring of newly qualified doctors (pre-registration house officers – PRHOs) by senior nurses for the first six months of their clinical practice. The setting for this study were the wards within four NHS Trusts across the South West of England where all the participating newly-qualified staff were practising.

An ethnographic approach, which allows the use of both qualitative and quantitative methods of data collection, was adopted for this study. Data collection involved predominately qualitative methods (one-on-one interviews). Quantitative methods (questionnaires) were, however, also employed. The total number of participants in this study included 69 mentors (senior nurses), 64 mentees (PRHOs), four project leaders, four clinical tutors and three post-graduate managers, of which four clinical tutors, four project leaders, two postgraduate managers, 12 mentees and 12 mentors were interviewed.

The objectives, pursuant to the aim, were to:

- Examine the experiences of interprofessional mentoring for mentors, PRHOs and those involved in implementing the scheme;
- Identify factors that support or hinder interprofessional mentoring among nurses and doctors;
- Identify any benefits for the learning path of nurses and doctors;
- Explore perceived benefits for healthcare delivery.

The mentoring period for this study was six months and data collection occurred at the beginning and at the end of this period. All those involved

completed a pre- and post- questionnaire. Additionally, some of the mentors, junior doctors, clinical tutors and project leaders from each of the four participating Trusts were interviewed prior to the commencement of mentoring and after six months. The data was thematically analysed using a person-centred approach.

The findings from this study show that mentoring using an interprofessional method is a viable approach to supporting professionals, particularly during the early stages of their professional lives and in the current health service climate. Interprofessional mentoring was perceived as a means for supporting the personal and professional development of newcomers as well as the professional development of the mentors. Professionally it involved learning clinical skills through observation, increasing knowledge about the roles and responsibilities of other professional groups and their contribution to healthcare, and developing working relationships with other professionals. In terms of personal development, it helped develop increased confidence and thereby an ability to cope with stress, enhanced interpersonal skills, and improved communication skills. These benefits ultimately influenced the care received by patients, and provided improved staff job satisfaction and a more effective use of resources.

The main recommendations for interprofessional mentoring and the research process based on the findings of this study are as follows:

- The use of various means, e.g., shared learning, should be employed in the preparation of students during their training for collaborative work
- Training for medical staff should give attention to mentoring
- Interprofessional mentoring can be applied to any grade. For example, consultants or senior registrars can easily support the educational needs of senior nurses, such as nurse consultants or nurse practitioners, in the same clinical speciality.
- Clear guidelines for mentors, mentees and all hospital staff about the aims and objectives of interprofessional mentoring programmes.
- The process must receive the full support and backing of management and senior staff.

- Time should be allocated for training mentors and for meetings between mentor and mentee.
- The incorporation of interprofessional mentoring as one of the support systems within the hospital would be advantageous. This would necessitate the inclusion of interprofessional mentoring in hospital policy.

This study demonstrates that junior doctors can be mentored and receive support from senior nurses in the early days of their practice. Furthermore, this study provides an example of how interprofessional initiatives can be implemented on general acute wards.

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Author's declaration

I, Farnaz Heidari, declare that this thesis is my own personal work. The data collection, analysis and write up was carried out by myself, and that no other material but my own is being presented in this thesis.

Chapter 1

Introduction

1.1 Setting the scene

The inception of this study was the result of personal interest in the experiences of newly qualified staff and in the collaboration between the different professional groups working within the healthcare service. My interest in this area was stimulated by my involvement in a funded study with Bournemouth University, looking at the stresses of newly qualified health staff. It has been well documented over many years that the transition from being a student to a newly qualified, accountable practitioner can be very daunting and challenging (Wilkinson and Harris 2002, Bick 2000, Gerrish 2000, Charnley 1999, Maben and Macleod Clark 1998). This continues to be of concern for both healthcare educationalists and employers. The need for support and mentoring of new staff has been acknowledged and encouraged. In addition, the rapid changes within health care in recent years have called for additional supportive measures for new staff as well as an approach to health care that is more interactive and collaborative between the professions. The nature of education, however, has been predominately uni-professional to date, which has resulted in segregated activities in practice. The aim of this study was to examine whether newly qualified healthcare staff can be supported in their journey to become practitioners using an interprofessional approach. This chapter will introduce the study, and provide a background to the reasons for its birth, the research questions, and its aims and objectives.

1.2 The rationale for this study

The high level of stress that newly qualified staff experience as they make the transition from students to practitioners has been well documented (Ratanawongsa et al. 2007, Kjeldstadli et al. 2006, Lemp at al. 2005, Goldacre et al. 2003, Charnley 1999, Grainger et al. 1996, Firth-Cozens 1990, Kramer

1974). Personal reflection on the first day as a qualified nurse entering the ward, anxious at the thought of being asked a question and having to be accountable for clinical actions, confirmed the need for support in the early days of practice. Healthcare professionals, who have spent several years studying, do not find themselves fully prepared for practice and need support during the transitional period (Wilkinson and Harris 2002). This is a reality for all healthcare professions and is acknowledged by their respective governing bodies, which are exploring and developing support structures to allay the fears and anxieties experienced by new staff.

The professions of interest for this study were nurses and doctors due to personal association with, and experience of, these professions. In the United Kingdom there are a number of support mechanisms in place for newly qualified nurses and doctors. In medicine there is a one-year period after university and prior to full registration where junior doctors receive support and supervision from clinical tutors and educational supervisors in practice, for the purpose of professional development. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), introduced the concept of preceptorship in the early 1990s as part of continuing professional development, which is described as a period of support for newly qualified nurses. Experienced qualified nurses are trained and expected to act as mentors and preceptors for students and newly qualified nurses. Preceptorship was seen to be an essential factor in the smooth transition from student to professional practitioner (English National Board 1988).

In addition, current literature and professional governing bodies have acknowledged the need for an interprofessional approach to continuing professional development, since conventional approaches do not appear adequate in meeting all the educational and developmental needs of professionals in the current healthcare system (English National Board and Department of Health 2001, Headrick et al. 1998, National Health Service Executive 1996, SCOPME 1994). The New NHS Plan also highlights the importance of interprofessional working for effective service delivery with the aim of alleviating some of the gaps and inefficiencies in health care. The Department of Health (DoH) has, therefore, placed great emphasis on an integrated collaborative and teamworking approach among healthcare

professionals to improve patient care (DoH 2000c, 1998) and more funding has been made available to explore ideas and possibilities in this area. This aspect of health care has now been specifically included in the new educational programme for new doctors. In the General Medical Council's (GMC 2005) document on general clinical training for new doctors, team working and communication with other healthcare professionals have been placed high on the agenda, as skills required for new doctors to acquire and practise. The document suggests that Pre-registration House Officers (PRHOs) need to demonstrate their ability to work effectively in teams that bring together different professionals in order to provide high quality health care.

The provision of supportive measures for new healthcare staff using an interprofessional approach is not without its challenges. On examining the literature, it became clear that there is no real consensus about the meaning of 'interprofessional working/education' and different terms, such as multiprofessional, multi-disciplinary, team working and shared learning, are used interchangeably adding to the confusion and uncertainty around these concepts (Lax and Galvin 2002, Øvretveit et al. 1997). Interprofessional working is often seen as team working.

A collaborative approach to provision of care needs to cut across professional boundaries and cultures. Developing professional identity and a body of knowledge has been the concern of all professional groups which has led to uni-professional education, differences in status, practice and language, and has resulted in conflicts between the professional groups in practice settings (Øvretveit et al. 1997, Porter 1995). Nursing and medical students having spent three to five years in separate training programmes, once qualified and in practice find themselves being very dependent on each other to provide patient care. The skills of communication and interaction need to be learnt during training and then reinforced in practice, both through opportunities for collaborative working and through observation of senior staff engaged in effective interprofessional practice.

Although the concepts of support for newly qualified staff and interprofessional working and learning, are encouraged, the rapid changes within the National Health Service affect the implementation of research evidence, initiatives and ideas. The changes in the role of sisters/charge nurses,

the changes in working hours for junior doctors and the greater demands on staff time all contribute to the pressures that healthcare staff are facing (Le-Fanu 1998, Walsh 1997). Any new initiative is sometimes perceived as extra pressure on staff and is therefore not always implemented or explored (Walsh 1997, Funk et al. 1991). Interprofessional working has also been difficult to implement in many healthcare settings. Although there are some clinical areas that have successfully achieved a team approach to service provision, e.g. care of the elderly, mental health and intensive care, these are not universal. There is also little empirical evidence as yet about the effectiveness of interprofessional working on patient care (Barr et al. 2000). Exploring interprofessional working is a complex task and therefore needs to be systematic and gradual. However, there is a need for more initiatives to build on the existing evidence around interprofessional working.

1.3 The study

This study involved an interprofessional approach to mentoring of newly qualified doctors (PRHOs) by a senior member of staff for the first six months of their clinical practice. From personal experience of working in the clinical area, what appeared to be of great benefit was the exploration and utilisation of various initiatives for easing the transition into practice for new staff. Mentoring has been identified as a useful approach for the support and development of staff (BMA 2004, Standing Committee on Post-graduate Medical Education 1997). It is one of the most important relationships a person can have early in their career (Levinson 1978) and has been found to enhance the personal and professional development of individuals throughout their careers (Fowler and O'Gorman 2005). Mentoring was, therefore, adopted and utilised for this study. What was new about this method of mentoring, however, was the use of an interprofessional approach. For practical reasons and implementation purposes only two professional groups were involved in this study. Nurses and doctors were asked to take part because upon graduation they enter similar working environments, their work is intimately linked and they need to develop a close working relationship for effective healthcare

delivery. Once this system of mentoring is firmly established and evaluated, other related professional groups, such as physiotherapists, can be introduced gradually into similar programmes.

The only other instance of interprofessional mentoring of new staff that could be found in the literature occurred in 1998 at the Mid-Essex Hospital Trust, where senior nurses mentored junior doctors. Pearce and Blainy's (1999) evaluation of the scheme using postal questionnaires was positive. Benefits of the scheme were believed to be enhancement of interprofessional learning and the reduction in stress of the transitional period for new staff. However, the programme was short-lived and related literature lacks rigour, particularly in relation to the methodology used to evaluate the initiative. Most other studies and innovations in the area of interprofessional working and learning have not examined the concept of mentorship for newly qualified staff, but rather have centred on healthcare students and team working among health professionals (Freeth et al. 2002, Barr et al. 2000). Therefore, the concept of interprofessional mentoring for newly qualified staff is unexplored and is a new area for investigation.

The first challenge encountered during the implementation of this mentoring programme for junior staff, was the varied definitions and uses of the term mentoring within the literature. There were also differences in the understanding of the concept of mentoring between the two participating professional groups in this study. Therefore, the level and type of mentoring for this study was decided on at the outset to make the purpose of the scheme clear to all participants. Due to the uniqueness of this study, the lack of literature in this area and the newness of the concept for the professional groups, a generic definition of mentoring had to be used. The definition provided by the Standing Committee on Post-graduate Medical Education (SCOPME 1998, see literature review) appeared to be the most appropriate for this study because it did not involve any form of assessment or monitoring. Instead, mentoring was used solely as a means of supporting the learning and development of individual practitioners. Therefore, in this study, mentoring was defined as the support of junior staff by a more senior individual for the purposes of professional development, personal growth, confidence building in practice, understanding the role of other healthcare staff and the ability to interact with other

professional groups. In this way the mentee could learn from the expertise of the mentor, be supported in practice and have the confidence to share any anxieties or worries about their practice without it impacting on their assessment. In addition, there was the opportunity to learn from, and about, each other's profession. This, therefore, became the scheme's mandate for mentoring.

1.4 Aims and objectives

The aim of this study was to examine whether newly qualified healthcare staff can be supported in their journey to become a practitioner using an interprofessional framework to mentoring. The objectives, pursuant to the aim, were to:

- Examine the experiences of interprofessional mentoring for mentors, PRHOs and those involved in implementing the scheme;
- Identify factors that support and hinder interprofessional mentoring among nurses and doctors;
- Identify any benefits of interprofessional mentoring for the learning path of nurses and doctors;
- Explore perceived benefits for healthcare delivery.

In addition to the aforestated aim and objectives, there were some personal aims and objectives as well. The research process and the experience of managing a study on this scale became a great learning opportunity. Furthermore, the study became a means of developing personally as an academic writer. Rolfe (1997) suggests that the function of writing is more than just descriptive but also allows for analysis (know what you know and how you know it) and synthesis (constructing something new). He suggests that we do not know what we want to write until we actually begin to write. By writing, I am not just creating ideas to present to the reader but wish to create a means to understand and to discover myself as a researcher. Hence reflection was integral to my personal journey and is presented in the final chapter.

1.5 The initial process

The study began in January 2001 with a consultative process involving individuals concerned with the education and training of new house officers at each of four Trusts, in the South West of England, that were identified as willing to take part in an interprofessional mentoring project. This was a project between a university in the South of England and the Regional Health Authority. A project lead that worked with and was valued and respected by both doctors and nurses was identified at each trust to assist with the administration of the scheme and with data collection.

Mentors were identified from among senior nursing staff who had more experience of mentoring and in many instances worked at the Trusts for a longer period of service than their medical counterparts. Some senior doctors had themselves only been in the Trust for a few weeks and were not as familiar with the working conditions of the wards and the environment of the Trust. This was important since some of the stresses and anxiety expressed by new staff were due to the unfamiliarity with the wards and the Trust. Another factor taken into consideration was the greater availability of nurses for the newly qualified staff in comparison with senior doctors who may not be as accessible to junior staff. Therefore, for practical reasons in this study, junior doctors were the mentees with senior nurses acting as their mentors. Mentors were identified from areas that employed new house officers. This was done with the help of ward sisters who identified senior nurses with experience of mentoring and who met the criteria set for the study. The criteria were based on existing literature (Bain 1996, Craven 1996, Madison et al. 1994) and the knowledge gained during the pilot study (see chapter 3 on study design) at the first Trust that undertook this scheme. The literature around mentoring identified certain characteristics that are needed by mentors (Andrews and Wallis 1999, Neary 1997, SCOPME 1997, Bain 1996, Piemme et al. 1986). These include mastery of clinical skills, enthusiasm, organisational abilities, knowledge, self-confidence and patience. The mentors also needed to be approachable, clinically-based, accessible, flexible, responsible, non-judgemental, assertive, open-minded and advocates for the newly qualified staff.

The mentors, once identified, undertook a half-day training on the scheme and its practicalities. Upon completion of the training, the mentee and the mentors were introduced to each other, and the mentoring process began once the new house officers commenced working on the wards.

1.6 Research approach

An ethnographic approach was used for this study. Ethnography is the descriptive study of a culture. Within health care there has been a culture of uni-professional functioning. Should this study yield conclusive results about the benefits of interprofessional mentoring, it could influence the normal socialisation and culture of PRHOs. Therefore, an ethnographic approach was deemed to be the most appropriate method of investigation.

The mentoring period for this study was six months and data collection occurred at the beginning and at the end of this period. All those involved completed a pre- and post- questionnaire. Additionally, some of the mentors, junior doctors, clinical tutors and project leads from each of the four Trusts were interviewed prior to the commencement of the mentoring and at its completion (see chapter 3 on study design chapter).

1.7 The research questions

During the development and implementation of the mentoring scheme, a number of interesting areas came to the fore. From these, the research questions for this study were formulated as follows:

1. Of what benefit is mentoring for newly qualified doctors?
2. Can one profession mentor another?
3. Can a nurse contribute to the personal and professional development of a junior doctor?
4. Do mentors benefit from the experience of mentoring junior staff from a different professional group?
5. What influence does an interprofessional approach to mentoring have on the working environment?

1.8 Summary

Given that the provision of professional development and support for newly qualified staff is necessary particularly during the transitional period of becoming accountable practitioners, an interprofessional approach to supporting new staff seemed timely and appropriate. This study aimed to explore an interprofessional mentoring scheme for newly qualified doctors during the first six months of their professional careers.

Chapter 2

The literature

The aim of the initial literature review was to allow for a clearer understanding of the main themes of the study and to identify any research already carried out in the area of interprofessional mentoring. It also made it possible to identify any questions or gaps around the knowledge of mentoring and interprofessional working and learning. For the purpose of this literature review, two important areas were identified: interprofessional working and learning, and mentoring/preceptorship. The literature reviewed initially was largely limited to nursing and medical literature due to the focus of this study, but any relevant major works from other professions were also included.

In addition, two other areas were examined: the historical context of nursing and medicine; and the professional needs of new practitioners and the role of interprofessional mentoring in meeting those needs. In respect to the former, I believed this was necessary as it contributed to my understanding of the challenges to interprofessional working and learning. It also helped to identify factors from each professional background that can enhance interprofessional mentoring. As to the latter, it has been widely acknowledged that new practitioners are in need of extra support during the early days of their practice. The transition from being a student to an accountable practitioner has been explored within both the nursing and medical professions and an examination of the literature highlighted the needs of new staff and how interprofessional working and mentoring can assist in meeting those needs. However, the role of interprofessional mentoring in supporting newly qualified staff has not been fully investigated.

The search of the literature was thorough and included a range of sources, such as, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and the British Education Index (BEI). Because the changes within the health service and the nursing and medical professions have been immense, I believed it more relevant and important to limit the search to the last 25 years to incorporate

all recent changes and reforms. However, a few seminal texts previously published were also included.

The remainder of this chapter is divided into the four areas identified above, with a concluding section to examine the implications of interprofessional mentoring for newly qualified practitioners.

2.1 Transition to new practitioner

The transition to accountable professional practitioner has been reported as being fraught with anxiety and feelings of inadequacy (Ratanawongsa et al. 2007, Kjeldstadli et al. 2006, Lemp at al. 2005, Goldacre et al. 2003, Paice et al. 2002, Peterlini et al. 2002, Charnley 1999). The first few months of practice have been identified as causing high levels of stress. Several factors have been implicated such as inadequate preparation for practice, pressures of the work environment, lack of support and opportunities for continuing education. This section examines the experience of new practitioners and reviews the educational background from which they approach their new roles. Within the UK, shortage of doctors, nurses and hospital beds, as well as rapid changes and radical reforms within the health service (GMC 2005, McKee 2002, DOH 1997, 1999, 2000a), have led to the concept of skill mix of professionals and the redefining of roles and responsibilities (Rees 2000). This has had implications for both nursing and medical education and preparation for practice.

Nursing and medicine have traditionally each had a very different provision of education. That of nursing was based on an apprenticeship-style model where the students received a wage and were counted in staffing levels. Although linked with schools of nursing, students were given no formal academic accreditation or recognition until the early 1990s (Gerrish 2000). The concept of the professionalisation of nursing, and recognition of its scientific basis, led to the establishment of Project 2000 and the move from schools of nursing and midwifery into higher education. This meant that nurses received grants like other university students, became supernumerary in practice settings and studied to a

higher academic level (diploma or degree). However, studies such as those by Luker et al. (1996) and Maben and Macleod-Clark (1998) found that, although nurses were perceived to have a greater knowledge, they lacked clinical and managerial skills, as well as confidence, at the point of qualifying. For this reason, the UKCC recommended, as part of a wider policy on post-registration education and practice, that new nurses should be supported through a preceptorship programme for the first four months after qualification (UKCC 1991, 1993). Preceptorship, a teaching/learning approach in which newly qualified staff are assigned to work alongside an experienced practitioner in the same practice setting, aims to span the gap between the transition from being a learner to an accountable practitioner (Mamchur and Myrick 2003, Lee 1997). However, preceptorship is only a recommendation and is not compulsory. As a result, such schemes vary from one Trust to the next (Bain 1996).

In contrast medicine, with its solid scientific and theoretical base, has traditionally been situated in higher education. Most countries follow the Flexnerian curriculum, which advocates a separation between the basic and clinical sciences, with the former being taught in the first two years of medical school and the latter in the proceeding years. However, most countries have been going through reform in medical education, both in response to an increase in the extent of knowledge required by doctors and a perceived need to change the public attitude to medicine to one of life-long learning. Notwithstanding these reforms, most of the knowledge gained by medical students is factual, with less emphasis on general competencies and practice development (Ashley 2000, Towle 1998). The General Medical Council (GMC) also identified factual overload in the curricula, with little evidence of self-directed learning, evaluation of evidence or critical reflection and thought (Rees 2000, GMC 1997). Ashley (2000) further illustrated the lack of experiential learning for undergraduate medical students. He advocates Kolb's model whereby learning is acquired in a cyclical manner through experience, reflection on the experience, and subsequent theorising leading to new action, at which point the cycle is then repeated. There is a need for undergraduate students to have more practical experience continuing into the PRHO year. Dent

and Gillard (1998) assert that those involved with pre-registration training accept that house officers are inexperienced and require training and support. Ashley (2000), as well as SCOPME (1997), indicate the importance of a period of apprenticeship or the need for a mentor to guide, support, teach by example and be a role model, thereby aiding the learning and training of PRHOs.

One manifestation of the inadequacy of preparation for practice is occupational stress, which is highly prevalent among newly-qualified staff, as demonstrated by research (Kjeldstadli et al. 2006, Lemp at al. 2005, Paice et al. 2002, Jones et al. 2001, Charnely 1999). Occupational stress can be defined as the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker (Garfield 1995). Occupation stress is a common factor in the health services leading to staff sickness and absenteeism (Clegg 2001, Firth-Cozens and Payne 1999). The health service loses the equivalent of 6% available working time per employee in comparison to 3.4% in the private sector (CBI and Local government examine sickness absence 1995) and the direct cost of absent nurses was in excess of 1 billon pounds per year in several NHS Trusts, with occupational stress being accepted as the major factor in the high sickness rates in the health service (Clegg 2001). In their studies, both Paice et al. and Jones et al. used postal questionnaires (2,456 and 256 respectively) while Charnely's study involved interviews (n=18). All three studies found that the areas of competency and responsibility posed the greatest stress for newly-qualified staff. Lack of clinical skills was identified in a number of studies as a major stressor (Charnely 1999, Clark 1994, Calman and Donaldson 1991). Within nursing, this lack of confidence and skills arises from the greater emphasis that is now being placed on the academic aspects of the training, with reduced clinical experience in comparison with training programmes prior to Project 2000. The same is true of medical education, which places a great weight on theory while the assessment of clinical competency is not always adequate and is subsequently unable to '*look at how students perform skills and use their knowledge in day-to-day practice*' as attested by Jones et al. (2001, p578). Studies by Grainger et al. (1996) and Firth-Cozen (1987) demonstrate how PRHOs are vulnerable to

systematic abuse and have experienced symptoms of stress leading to high levels of depression and psychological ill-health. In addition to the stresses of being newly qualified, the healthcare professional has to deal with the added pressures of working in the National Health Service (NHS), which is continually reported as being under-resourced and overstretched (Alderman 1999, Charnely 1999). Heavy workload, high levels of responsibility, conflicting demands, exposure to emotional and physical dangers, and power and control (Rout et al. 1996, McIntosh 1995, Schaufeli et al. 1995, Coles 1994) are all pressures attributed to the NHS. The impact of these two major stressors can affect job satisfaction and commitment, leading to absenteeism, attrition and reduced quality of health care (Clegg 2001, Kushnir et al. 2000, Groenwegen and Hutten, 1991, Kunkler and Whittick 1991).

Lack of control and power can be an issue for newly-qualified staff, which adds to their stress (Dent and Gillard 1998). In a study by Menon et al. (1996 cited in Firth-Cozen and Payne 1999) that collected data on job stressors in samples of nurses and physicians, nurses reported higher levels of situational constraints and workload than did physicians, but physicians had higher levels of interpersonal conflict. Menon et al. speculated that these discrepancies were due to control differences between the professions. Nurses felt they had less control over their work and so were less able to reduce constraints or regulate workload, whereas physicians had more control over their workload but had more conflict with colleagues and subordinates possibly over control issues.

Other factors that lead to stress for newly-qualified staff are inadequate management skills, including management of their own workload, and lack of understanding of roles and responsibilities, of their own and other professions (Charnely 1999, Dent and Gillard 1998). However, these specific stressors may be overcome after the first few months of practice as they learn their roles and are better able to manage their time. Again the lack of, or inadequate training opportunities are major factors that impact on the development of newly-qualified staff (GMC 1997), particularly for PRHOs where the pre-registration year is effectively the final year of their medical education, requiring teaching, support

and supervision (Bligh 2002, Kushnir et al. 2000, GMC 1997). Much of the literature alludes to the lack of teaching opportunities for junior doctors, and the lack of training for senior doctors in teaching and support giving (Dacre 1998, GMC 1997).

The above stresses are experienced by newly-qualified staff (Paice et al. 2002, Jones et al. 2001). However, the experience of stress and the ability to cope with it vary between individuals and depend on a number of factors, such as the right job environment (Kushnir et al. 2000) or differences in personality (Payne 1999). Therefore, some newly-qualified staff are able to cope with the stressors better, either as a result of being in a supportive and caring environment (or team), or are able to find a suitable coping mechanism. One of the characteristics of a supportive environment is the opportunity to learn, particularly for PRHOs, who require teaching, support and supervision (Bligh 2002, Kushnir et al. 2000, GMC 1997).

The experiences of new practitioners are the result of both the preparation and training for practice and the impact of the environment in which they practise. Both of these are part of a long history of development for both the nursing and medical professions.

2.2 Nursing and Medicine: the historical context

Although nurses and doctors have a common aim, that of assisting patients through their illness, their respective professions have different histories and philosophies, and for centuries have functioned separately. Both professions have undergone and witnessed great change overtime through reforms dating back in the case of nursing to the time of Florence Nightingale in the late 1800s, and in the case of medicine much earlier. As a result of more recent reforms they have developed closer working relationships (Blue and Fitzgerald 2002). Each profession's respective history has contributed to the professionalism and socialisation of the members of that profession.

Medicine as an organised profession has a longer history than nursing, dating back to the 16th century. In 1518, the Foundation of the College of Physicians was formed, and in 1800 the Charter that established the Royal College of Surgeons was established. In 1815 the Apothecaries Act required individuals by law to enter a five-year apprenticeship programme and pass an examination. In 1832, the Reform Act meant that the profession became self-governing and by 1858 the Medical Registration Act came into being. The profession of medicine was seen to have the monopoly of health-related knowledge. This expertise and knowledge, along with an altruistic attitude which was a characteristic associated with health professionals, meant that the profession occupied a very important place in society, giving it the power to self-regulate and set its own codes of practice (Cruess et al. 2000).

With this power and knowledge also came status and prestige. It could be argued that society 'delegated' this power to the profession in the hope and belief that it would be used wisely and for the benefit of the user. As medicine became more complex, a system and an organisation evolved (Cruess et al. 2000) to include legislative structures and bodies for licensing. Although society did not have power over the profession, it had an expectation that it would assume responsibility for the integrity of its knowledge base, ensuring high standards through research. The trust that society had in the profession came in part from the way responsibilities were met by members of that profession. According to Emmanuel and Emmanuel (1996), there are three levels of accountability for doctors; fiduciary (responsibility to patients and colleagues), economic (responsibility to those who pay for the service), and political (responsibility to society for the health care of the population). The collegiality and cohesion of the medical profession has been obvious and well-known. There have been instances in recent years where hospitals and senior medical staff overlooked and, in some cases, covered up medical colleagues' malpractice and incompetence (The Bristol Royal Infirmary Inquiry 2001). As a result of these occurrences, along with the perceived self-interest and inaccessibility of doctors, society has, to a significant

extent, lost its faith in the profession and demanded transparency and assurance of quality of service.

Nursing, on the other hand, only acquired professional status in 1919 with the Registration of Nurses Act. At the beginning of the 19th century, nursing was viewed as menial work and nurses had a bad reputation (Clifford 1985). It was seen as low status work carried out mainly by women, since the tasks were considered as an extension of the work of a wife or mother (Parkin 1995), and was perceived as uninteresting and routine, with no need for training. Nurses lacked autonomy and received little financial reward. However, in the mid-19th century, significant reforms instigated by individuals, such as Florence Nightingale (Abel Smith 1960, cited in Clifford 1985), gradually transformed nursing into an organised profession. By the late 19th and early 20th century, formal training and education had been put in place. However, the level of training was set too high, and the resultant shortage of graduating nurses led to the establishment of different levels of nursing, i.e., registered general, registered enrolled and auxiliary nursing (Clifford 1985). This continued further with the development of new roles such as the nurse consultant; affording nurses the opportunity to develop and shape services for patients (Guest et al. 2004).

The role of women in society also had an impact in terms of the acceptance of nursing as a profession. Medicine was dominated by men and nursing by women. As the role of women in society began to change, with more women attending medical schools and more men receiving nurse training, a shift in attitude towards the nursing profession became evident. Medicine was seen as a model profession and nursing, an aspiring 'semi' or 'quasi' profession (Turner 1987).

Other factors that have led to the development of the nursing profession have included a structured training programme and a move into higher education in the late 1980s. The 1980s and 1990s also saw the development of the extended roles of nurses as advanced practitioners, nurse practitioners and nurse consultants. Nurses have campaigned over the years for nursing to be viewed as a profession in its own right, but Savage (1988) states that without power full professional status cannot be achieved. Nurses not only had to fight for a share of power within

healthcare that had, for many years, been in the sole possession of the medical profession, but then had to battle with society for acceptance as a profession. In its struggle for power and desire to wrest itself from under the shadow of medicine, nursing has been going through many significant and radical changes (Parkin 1995, Salvage 1995), for example, development of its own governing bodies, codes of practice and research programmes.

The relationship between nurses and doctors has been influenced by their individual histories and the way in which the professions have been perceived by society. According to Freidson (1984), traditional views of the professions were dominated by the freedom from social control that they had, and the ability to self-regulate, subject only to informal collegial control. Haug (1973) pointed to attributes that provided professionals with their prestige and respect in the past. These included the monopoly over a body of knowledge, the positive altruistic image and the power to set their own rules as to what constitutes satisfactory work. This perception singled them out from the layperson and society, thereby giving them prestige, respect, status, power and to a great extent, the authority to do as they pleased. This has been the case for medicine but not for nursing.

However, over the years, the status and respect of many professions has been lost (including that of doctors) and consequently their power has diminished. There are many reasons for this. First, public knowledge in all areas and fields has increased, particularly through the media and the internet, as well as through self-help groups that provide information to individuals (Walby et al. 1994). In addition, the complexities of specialised labour have meant that professionals rely more on others to be able to carry out their work to a higher standard, which is what society wants and expects.

The media have been a major contributing factor to the change in society's attitude towards various professions. They have highlighted flaws in self-regulation by bringing cases of unprofessional conduct and malpractice, which have gone unnoticed by the regulating bodies of the respective professions, such as the Bristol and Alder Hay Inquiries (The Bristol Royal Infirmary Inquiry 2001), to the attention of the public. This has caused the public to question the power and

status of professionals and to demand them to be more accountable. Therefore, social control is being called for and, according to Cruess et al. (2000), the professions and society must agree on the social contract of each profession.

This trend is a move towards the consumer model (Walby et al. 1994) whereby the profession provides expert advice and the recipient can seek alternative counsel. Haug (1977) has called this process the deprofessionalisation thesis. Freidson (1984) describes a second thesis called proletarianisation that emphasises the circumstances of professional work in large organisations and stems from Marx's theory of history. The belief is that, over time, professionals will be reduced to the status of a worker, less likely to be self-employed, and will lose all control over the body and practice of their work. This thesis places the emphasis more on economic and organisational factors, unlike deprofessionalisation, which stresses cultural and political phenomena. As employees of large organisations, professionals have to carry out tasks assigned by the organisation and supervised by a hierarchical process. Implications of this are also loss of power and a move away from self-regulation to social control due to demands of society. Within the framework of health care in the UK it appears that there are aspects of both these theses.

In the past there have been clear distinctions between the functions carried out by each profession. The sphere of doctors has been to diagnose and treat, while that of a nurse has been to care (Walby et al. 1994). Through this division of tasks, a hierarchical environment was created whereby doctors prescribe and the nurses carry out their requests. This has ultimately given doctors the greater share of the power within health care. Foucault (1980) describes power as a decentralised network of relations and is actually exercised rather than possessed. As a result of the historical relationship between nursing and medicine, power has become a strategy in the interaction of the two professional groups. However, as aforementioned, the relationship between nursing and medicine has begun to alter due to changes in health care as a result of reforms and dictates of society (Jones 2003, May and Fleming 1997, Mackay 1993). The nature of health provision has meant that doctors increasingly depend on others to deliver the specialist care

required. Medicine has had to devolve some of its role and tasks, and subsequently its knowledge and power, to other professionals, specifically nursing (Snelgrove and Hughes 2000). This is evidenced by the Scope of Professional Practice (United Kingdom Central Council for Nursing, Midwifery and Health Visitors 1992), which allows nurses to develop their expertise and expand their practice, take their own case-loads and be more involved in clinical decision-making (Guest et al. 2004, DoH 1999a).

The cultural ideology of medicine has been one of social control through technical expertise and authority. This ideology is particularly salient in medical socialisation as new doctors become assimilated into medical culture and develop their professional identity (Apker and Eggly 2004). This may also be true for nurses, although their ideology is based on their greater knowledge of the patient as a person. The social and emotional care of the patient presents a central element of nursing work (Snelgrove and Hughes 2000). This has shaped the culture of nursing and the socialisation of nurses into their profession. Through their uni-professional training and socialisation, each profession has developed its own values and beliefs, both about their own role and status, and about that of the other profession. This has led to the stereotyping of each other's professions, which subsequently affects interactions between them. As will become clear in this thesis, such stereotyping can be detrimental in their new roles where close collaboration is required.

2.3 Interprofessional practice

For the purpose of this study, both interprofessional working and education in health care have been incorporated into a single theme. There appears to be a substantial amount of literature about interprofessional education (learning and training) but less about interprofessional working. However, the literature on interprofessional education is essential in understanding interprofessional working, as education is ultimately about improving practice and care provision. In the literature the term 'interprofessional', has been used interchangeably with words

such as 'multiprofessional', 'multidisciplinary', 'collaboration' and 'team working'.

The trend in recent years has been for a move towards interprofessional education, training and working in order to enhance team working, ensure efficient use of resources and improve patient care (Marshall and Gordon 2005, Barr 2000, Hammick 1998, DOH 1997). This drive towards increased collaboration between healthcare professions has been spurred on by concerns about quality of care provision. There has been a greater emphasis by the Government to increase interprofessional learning and working (DoH 2000a, c, 1998, 1997) and to develop means of incorporating it into continuing professional development (CPD) and lifelong learning (DoH 2000a). Although a body of knowledge is developing, there is still a lack of empirical evidence about the effectiveness of an interprofessional approach (Barr 2000). A Cochrane review by Zwarestein et al. (2004) concludes that most studies on interprofessional education lack the methodological rigour needed to convincingly understand its impact on professional practice and healthcare outcomes. The main methodological difficulty identified by the authors was the lack of controlled groups in these studies. As with most Cochrane studies, only randomised controlled trials (RCTs), controlled before and after trials and interrupted time series studies were considered for their review. In another review by Zwarenstein and Bryant (2004) on interventions to promote collaboration between nurses and doctors, they suggest that interventions in this area are complex and require large samples, which is beyond the means of many studies. Although RCTs are generally believed to be objective, free of bias and produce robust conclusions (as evidenced by Cochrane, which focuses on RCTs), many are questioning the use of RCTs to evaluate complex interventions. McCormack and Greenhalgh (2000) examined the data from the UK prospective diabetes study (UKPDS 1998) and found that although the benefits of one drug were evident, the results were presented with a positive spin on the other drugs. They believe that studies like these illustrate the principle that interpretations of clinical trial results are often neither objective nor value-free, but rather researchers, authors and editors are highly susceptible to interpretative biases.

2.3.1 Definition of the term 'interprofessional'

The first difficulty encountered in the literature was the lack of clarity and consensus around the term 'interprofessional' (Hale 2003, Royle et al. 1999, Soothill et al. 1995, Lankshear et al. 1996). This ambiguity about the term interprofessional has contributed to the difficulties of implementing interprofessional innovations. Lankshear et al. (1996) state that wide variations in definition and cohesiveness have been reported, both within and between specialities. Headrick et al. (1998) explain that interprofessional working can be viewed as a spectrum '*with more loosely co-ordinated efforts of collaboration at one end and more tightly organised work of teams on the other*' (p1). Leathard (2003) provides a list of terms that have been used to denote an interprofessional approach, dividing them into three categories: concept-based, process-based and agency-based. Examples include interdisciplinary and multidisciplinary under the concept-based category; teamwork, collaboration and shared learning under the process-based category; and interagency and cross-agency in the agency-based category. A number of definitions about interprofessional learning have been put forward. The one with greatest currency is that of the United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) which highlights that interprofessional education occurs when two or more professions learn with, from and about one another to facilitate collaboration in practice (Barr 2000). Parsell and Bligh (1998) have provided distinct definitions for the following terms which are used interchangeably:

Interprofessional: learning activities involving two professional groups

Multidisciplinary: learning activities involving members of differing branches of one professional group

Multiprofessional: activities involving three or more professional groups.

Although the distinction made is in relation to learning rather than working it can be usefully applied in the domain of work. According to Nyatanga (2002), the subtle variations between the terms are, for the most part, semantic and are in some cases contradictory. Although definitions do exist, there are no simple

working definitions that would help practitioners to implement interprofessional initiatives. An explanation of interprofessional working that clarifies the necessary components to make such practices possible is provided by the NHS Executive South West (1999):

> *Interprofessional working is not about fudging the boundaries between the professions and trying to create a generic care worker. It is instead about developing professionals who are confident in their own core skills and expertise, who are fully aware and confident in the skills and expertise of fellow healthcare professionals, and who conduct their own practice in a non-hierarchical and collegiate way with other members of their working team, so as to continuously improve the health of their communities.* (p7)

This definition identifies two components for effective interprofessional working: confidence in one's own abilities and skills, and the need for equal value to be given to the contribution made by each profession with no hierarchal system attached.

2.3.2 Interprofessional working – content and structure

Most of the literature and Government reports have identified benefits of interprofessional education and working. These include improved communication, increased understanding of roles and responsibilities, improved patient care, more efficient and effective use of resources, breakdown of hostility between professions and job satisfaction (Lax and Galvin 2002, DoH 2000a, 2000c, Freeman et al. 2000, Leaviss 2000). Despite these oft-cited benefits, there have been few, if any, studies that have been able to measure them. Zwarenstien and Bryant's (2004) Cochrane review on interventions to promote collaboration only found two studies of acceptable methodological quality that offered limited evidence on the benefits of collaboration amongst healthcare staff. The positive influence of team working has also been identified in other work place environments. Mullins' (1999) review of studies in industry concluded that true team working and collaboration enhances productivity and quality of work,

encourages innovations by taking advantage of opportunities and improves the motivation and commitment of its members.

Many purposes have been identified for interprofessional education and working. Payne (2000) summaries six purposes for multiprofessional work:

- Bringing together skills;
- Sharing information;
- Achieving continuity of care;
- Apportioning and ensuring responsibility and accountability;
- Coordinating and planning resources;
- Coordinating and delivering resources for professionals to use for the benefit of service users.

Payne further explains that interprofessional working goes further than multiprofessional working because it necessitates professional groups to make adaptations to their role to take account of, and interact with, the roles of others. Interprofessional education has been developed to facilitate collaboration in the workplace by changing negative attitudes and perceptions (Carpenter 1995), enhancing trust and communication between professions (Carpenter 1995), reinforcing collaborative competence (Barr 1998), enhancing job satisfaction and easing stress (Barr et al. 1998), and creating a flexible workforce (DOH 2000c).

In order to achieve such desirable outcomes, learning to work in an interprofessional environment needs to happen early in the education of healthcare professionals (Hall and Weaver 2001). Mackay et al. (1995) also advocate that positive attitudes to inter- and multi- professional working are best engendered during pre-qualification education, and that this should include the development of team-working skills (Areskog 1995). Furthermore, Horak et al. (1998) suggest that interprofessional collaboration can be better facilitated if shared learning occurs at the early stages of a health professional's education. However, some would argue that one's own professional identity would not develop through interprofessional education, and that developing a sound body of knowledge, an occupational identity and security in one's own discipline first, through a uniprofessional education, would be of more benefit (Mariano 1999, Soothill et al. 1995).

With the development of an occupational identity, professional boundaries and cultures are formed, which are often difficult to change. Freeth's (2001) review of an interprofessional skills centre at St Bartholomew's hospital showed that differences in the cultures and structures of the nursing and medical professions sometimes created misunderstanding and always made decision-making processes slow. A question that arises therefore, is whether it is better to develop professional identity first and then battle with any boundaries that arise as a result, or whether every step needs to be taken to prevent the development of professional identity, replacing it with a healthcare identity by combining the education of healthcare workers.

Parsell and Bligh (1999) suggest that a conflict exists between the retention of professional identities through adherence to a discipline-based approach to learning, and a readiness for shared expertise with other students through team-based approaches to learning. This poses an obstacle to interprofessional education which is further intensified by the absence of a culture of collaboration and in some cases a tradition of enmity (Freeth 2001). Pryce and Reeves (1997) highlight further obstacles, which may stand in the way: students' differing prior educational background and levels of attainment, knowledge base, educational approaches and requirements for professional accreditation

Requirements for effective interprofessional working include common goals and shared objectives, communication, commitment to collaboration, appropriate organisational structures and training (GMC 2006, Freeman et al. 2000, Lax and Galvin 2000, Payne 2000, Parsell and Bligh 1998, Ryan and McKenna 1994). The study by Freeman et al. (2000) used a case-study design to explore the issues around professional interaction that inhibited or supported team-working. Six teams from different specialities and from both acute and community settings (e.g. a primary healthcare team, a medical ward team and a diabetes team) were observed for a three-month period. In addition, interviews were conducted with team members, and a document analysis and pictorial representation of teams were undertaken by participants. They found that the perceptions and philosophies held by individuals engaged in interprofessional working collectively shaped a shared

vision, influenced communication, role understanding and valuing, thereby affecting the team functioning.

Freeman et al. identified three philosophies of team-working from their research:

- Directive: this philosophy was based on an assumption of hierarchy, where one person would take the lead by virtue of status and power, thereby directing the action of others. This philosophy was frequently held by members of the medical team and non-specialist nurses.
- Integrative: this philosophy placed importance in and valued the contribution of each team member in order to practice collaborative care and therapy. Communication was viewed as vital and included wide discussions and negotiations. This philosophy was mainly observed in the therapy and social work professions and to a limited extent, in nursing.
- Elective: this philosophy was based on a system of liaison where practitioners worked autonomously and referred to other professionals as and when they perceived there was a need.

The study by Freeman et al. suggests that a crucial factor for team working is that professionals' beliefs are challenged and discussed so that a negotiated way forward is found. This calls for an understanding of team working processes, and requires professionals to be educated and trained to prepare them for this type of working. This needs to be done as part of the basic education to help prevent professionals from becoming entrenched in the attitudes and behaviours inherent in their own professional socialisation. However, according to a national survey by Miller et al. (1999), few professional education programmes explicitly address team working issues, and fewer still address them in a multi-professional educational context. Freeman et al.'s (2000) study did provide valuable findings, but their examination did not extend to the assessment of each type of speciality, e.g., a primary healthcare team versus a medical ward team. It could be argued that some specialities lend themselves to team working regardless of the type of philosophies held by professionals, and that the nature of the work in some specialities requires the different members to have an integrative approach to team

working. Another factor that was not clear from Freeman et al.'s study was the type of observation conducted. By way of example, participatory observation where the researcher is part of the team, would have provided greater insight.

A quantitative study using postal questionnaires sent to members of 152 community rehabilitation teams in the UK by Enderby (2002) showed similar findings. She found that teams were affected by a lack of knowledge about team functioning and the roles of each profession. This was attributed to the different cultures, language and management practices of the professional groups involved. She also concluded that developing team working was a challenge because members may not have time to get to know each other personally or professionally. Therefore, it is important to establish and maintain team cohesiveness on an on-going basis as membership changes and activities evolve over time. Although this study reached some important conclusions, inadequate information about the research design itself made it difficult to evaluate the findings. For example, it was not clear what professional groups responded to the questionnaire; such information may have identified the professional groups more likely to adhere to a team approach.

Leaviss (2000) conducted a semi-structured telephone interview with 15 participants of a two-day pilot multiprofessional course for final year undergraduate students at the Faculty of Medicine, University of Liverpool. The sample included doctors, nurses, dentists, occupational therapists, physiotherapists, therapy radiographers and an orthoptist. The study examined the perceived effect of the course on the working practices of newly-qualified staff who had participated in the course as students, after one year of practice. The aim of the course was based on the identified outcomes of shared learning by Funnell (1995). These included increasing students' understanding of the roles and perceptions of other professionals, promoting future team-work and cooperation between professional groups, contributing to students' knowledge of a particular subject matter and aiding students' development of practical skills. The major finding from this study was improved working relationships due to increased knowledge of the roles and contributions of other professionals. The course did not however

change negative attitudes developed by one professional group about another. It would be naïve to assume that a two-day course could have a major impact on the attitude and working practices of professionals after at least three years of uniprofessional education and socialisation. To date, this has been a major problem with interprofessional education, which has consisted of short duration courses mainly at post-graduate level (Freeth et al. 2002). This study like many others did not provide enough information about its methodology, thereby rendering its conclusions and generalisations limited.

The above studies demonstrate a fundamental problem with research in the area of interprofessional education and working, namely that it is difficult to deduce essential information about the methodology or the aims of many of the studies (Barr et al. 2000). In their review of evaluations of interprofessional education, Barr et al. (2000) also found that the clarity with which research methods, findings and interprofessional learning processes were reported was often less than adequate. Barr et al. conclude that '*without clear presentation, evaluations cannot be replicated and compared, nor can the implications for the design and delivery of interprofessional education be determined with confidence*' (p38). Nonetheless most of the studies allude to the difficulty of changing attitudes and beliefs about one's own profession as well as the working practices of other professional groups. Education and commitment are required to help develop a new attitude towards collaborative working. What has also become evident is a need for more experience in researching this area in order to develop methodologies to evaluate the effectiveness of interprofessional working and education.

2.3.3 Summary

In summary, interprofessional education and working aims to improve overall service planning and delivery, increase efficiency of service delivery, increase patient satisfaction, reduce duplication of services, and increase staff moral and job satisfaction (Gair and Hartlery 2001, Bennett-Emslie and McIntosh 1995, Robinson and Wiles 1994). The aims of interprofessional collaboration are

achieved by a number of means, which include shared vision and goals, understanding and valuing the roles and contributions of other professional groups, constant communication, flexibility and equality between the professions, and respect for other professions (Leathard 1994, 2003). There is still, however, uncertainty about the effects and benefits of interprofessional education and working. There remains the need to develop tools and methods of researching the effectiveness of an interprofessional approach in health care. Barr et al. (2000) identify the need to widen the range of methodologies employed and to strike a balance between evaluation of process and outcome.

2.4 Mentoring

The review of the literature showed that there are a number of terms used interchangeably with mentoring, such as preceptoring, apprenticeship, supporting, coaching and role-modelling. Mentoring has a long history, dating back to Greek mythology where Odyssey entrusted his son to a friend to be a guardian and a tutor-advisor to him (Freeman 1998, Morton-Cooper 1993). Mentoring in various forms has had application in both nursing and medicine but the term mentoring is perceived and used differently in each of these professions.

Mentoring as a term is relatively new within the medical profession (SCOPME 1997) however as far back as 1815, the Apothecaries Act (which first regulated the practice of medicine) required those aspiring to practice to become apprenticed to an experienced apothecary. In the Hippocratic Oath, doctors pledge to hand on their precepts, lectures and all other learning to those pupils who are duly apprenticed (meaning junior doctors). Over the years, different systems were put in place to help the socialisation of junior doctors into the profession by learning from their seniors with greater experience of the profession (Bleakley 2002, Freeman 1998). Bleakley emphasises that the pre-registration year, in essence, offers an apprenticeship where junior doctors are attached to consultant-led 'firms', generating a variety of formal and informal ward-based educational opportunities.

Traditionally, consultants have acted as educational supervisors for junior doctors with responsibility for education and support. Difficulties identified with this system include the lack of training of senior doctors to take on such a role, the usefulness of the support depending on the willingness of the individual senior doctor to carry out the role effectively, the predominant use of a pedagogical approach, and the relationship being linked with the monitoring and assessing the performance of the junior doctor. To date, this process of supervision for junior doctors has not guaranteed adequate or universal support for the personal and professional development of new doctors, as evidenced by the number of studies on the stress levels of junior doctors and the difficulties in retaining doctors in the profession (Bleakley 2002, Connor et al. 2000, Spector 1999, Firth-Cozens and Payne 1999, SCOPME 1998, Spector and O'Connell 1994). For this reason, the medical profession has been exploring models and methods for improving the support provided to trainees and junior doctors.

The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) published a document in 1998 based on gathered evidence from experts in the field of mentoring over a two-year period. The committee strongly recommended mentoring as a valuable part of a framework of personal, professional and educational support for doctors. The British Medical Association (2004) has also strongly encouraged access to mentoring at all levels throughout a medical practitioner's career. According to SCOPME, mentoring is most effective if it is voluntary, confidential and void of assessment. It defines the process as:

> *a voluntary relationship, typically between two individuals, in which the mentor is usually an experienced, highly regarded, empathic individual, often working in the same organisation, or field, as the mentee; the mentor, by listening and talking with the mentee in private and in confidence, guides the mentee in the development of his or her own ideas, learning, and personal and professional development. Mentoring should be a positive, facilitative and developmental activity and should not be related to, nor form part of, organisational systems of assessment or monitoring of performance.* (SCOPME 1998, p12)

Mentoring has been an integral part of the nursing profession for some time. The terms 'mentoring' and 'preceptorship' have been used interchangeably and were familiar to most British nurses in the 1980s, with the inspiration coming mainly from business and commercial fields (Morton-Cooper and Palmer 1993). Darling (1984), who influenced the nursing field in America with her work on mentoring, admits that nursing adapted concepts of mentoring from predominately male dominated professions and that transferring empirical and anecdotal evidence from a male dominated profession to a female dominated one can further complicate understanding and application.

However, mentoring has now been part of the culture of nursing for many years (Marshall and Gordon 2005). The process has been refined to meet the needs of the profession and many nurse mentors have a clear understanding of what mentoring means within their profession. For the most part, mentoring is provided for student nurses and midwives, which becomes part of the process of the socialisation of nurses whereby they emulate qualified nursing staff and learn how to 'become' a nurse (SCOPME 1998, Morton-Cooper and Palmer 1993). In 1987, the English National Board (ENB) referred to mentors as wise reliable counsellors and trusted advisors, and in 1990, City University, London, further clarified the role of a mentor as:

> *an appropriately qualified and experienced first level nurse/midwife/health visitor who, by example and facilitation, guides, assists and supports the practitioner in learning new skills, adopting new behaviours and acquiring new attitudes. An individual must not function as a mentor and an assessor to the same student during the same placement.* (p1)

Interestingly, as in the definition from the SCOPME, the ENB also state that the mentor should not have any part in the assessment or monitoring of the mentee.

Within the nursing profession, once nurses qualify they have a preceptor who aids their socialisation into the workplace and helps them gain the necessary skills to function as a team member. Morton-Cooper and Palmer's (1993) definition of

preceptorship in nursing is similar to the definition of mentoring by SCOPME (1998). The two definitions offer a common ground for both of these professions and meet the requirement of this study, i.e., to provide a support structure for newly qualified staff. Morton-Cooper and Palmer state that '*preceptorship is a form of educational relationship which is intended to provide the newly-qualified professional with access to an experienced and competent role model, a means by which to build a supportive one-to-one teaching and learning relationship and a smooth transition from learner to accountable practitioner*' (p99).

2.4.1 Definition of the purpose and benefits of mentoring

The literature review showed that, like the term 'interprofessional', mentoring also lacks a clear definition and consensus (BMA 2004). This makes the standardisation of mentor preparation, as well as implementation and evaluation activities, difficult (Cahill 1996, Sachdeva 1996). Mentoring means different things in different organisations and for different professions (Hutton-Taylor 1999, Freeman 1998, Neary 1997, Cahill 1996, Sachdeva 1996). Many terms are used in the literature either interchangeably with, or in relation to, mentoring. These include preceptoring, role modelling, coaching, supporting, guiding, supervising, teaching or sponsoring (Wilson 2004, Waters et al. 2003, Bleakley 2002, Freeman 1998, SCOPME 1998, Sachdeva 1996, Speizer 1981, Levinson 1978). It could be argued that most of the words used can be, and are attributes or characteristics of mentoring itself, i.e. a mentor acts as a role model whose actions the mentee emulates, or a mentor teaches the mentee new skills or guides the actions of the mentee (Bleakley 2002, Freeman 1998, Sachdeva 1996). Merriam (1983) states that mentoring is defined according to the particular setting in which it occurs and therefore has different meanings in different contexts. Merriam continues that:

> *...mentoring is not clearly conceptualised, leading to confusion as to what is being measured or offered as an ingredient of success. Mentoring appears to mean one thing to developmental psychologists, another thing to business people, and a third thing to those in academic settings.* (p169)

Mentoring, therefore, needs to be flexible to meet the differing needs of the profession and the individual. A study by Waters et al. (2003) evaluated a pilot mentoring programme for new nurse managers in isolated rural areas requiring professional development and a support network. The study consisted of pre- and post- programme questionnaires and post- programme telephone interviews. The findings showed that mentoring fulfilled different needs at different times. Consequently, the needs of the mentee drove the relationship and meant that the mentors had to have all the characteristics and skills to meet those needs. At times, the mentors were required to teach or perhaps just guide or listen. A criticism of the study was the small number of responses to the questionnaires, which meant that only descriptive and comparative statistical analysis could be carried out.

Learning and support are the main purposes and benefits of mentoring identified in the literature (Bleakley 2000, Freeman 1997, Alliot 1996, Levinson 1978). However, in some professions such as business organisations, mentoring has a less altruistic theme and is used as a promotional activity, whereby the mentor acts as a sponsor to ensure the career progression and success of an individual (Freeman 1998). Rawlins and Rawlins (1983) suggest that, in the business arena, mentoring can advance careers:

> *Mentors teach, advise, open doors for, promote, cut red tape for [the protégé]... show the politics and subtleties of the job...thus helping them [protégé] to succeed...most important, mentors have skills, knowledge and power that protégés lack and need.* (p116)

It could be argued that most professions see the purpose of mentoring to be essentially the same. However, the language used in each profession and the differing emphases placed on certain aspects of mentoring can make it appear as though mentoring is a completely different activity. For example, in business culture, mentoring is about teaching and advising, and showing the way the organisation functions, but with a stronger importance given to the final outcome, i.e. promotion. It could be said that in health care the same thing applies, because junior staff need to learn the necessary skills and demonstrate their ability to take on new tasks and roles to become more senior members of staff. Mentoring in

nursing is mainly used in the teaching and assessment of students. Interestingly, mentoring is not only about teaching nursing skills and knowledge but also about the socialisation of students into the profession and about learning the inherent values and standards. Again, through role-modelling and instructing, students learn how to become nurses. On the other hand, the term used for the support given by senior staff to junior staff during the early days of practice is preceptorship. Within the nursing literature, the preceptor is described as a nurse who teaches, counsels and inspires, serves as a role model and supports the growth and development of the novice for a certain amount of time, in order to socialise them into a new role (Morrow, 1984, cited in Bain 1996). This description of preceptoring correlates with the purposes of mentoring in other professions, which again demonstrates the difficulty of gaining consensus about the aims and objectives of mentoring and of comparing findings from different studies.

A Canadian study by Dibert and Goldenberg (1995) found that commitment to preceptorship correlated with the perceived benefits, rewards and support for the preceptor and with the individual's extent of preceptorship experience. Their study consisted of a four-part questionnaire using a descriptive, correlational design. The sample involved 59 preceptors working at an urban teaching hospital in Ontario. The questionnaire scales were developed by the researchers and were piloted with 10 preceptors in the same environment. The findings showed that perceived benefits, rewards and support were more important in obtaining commitment to preceptoring than the years of nursing practice. This is a useful finding since, in most cases, senior nurses are identified as better mentors; but if the support and rewards are not available to them, they too would not be as effective in the preceptor role as assumed.

The rewards and benefits identified by the preceptors were the opportunities to assist and teach new staff, the improvement of their own teaching skills, personal satisfaction, sharing their knowledge as well as an increase in their own professional knowledge. It was interesting that the preceptors in this study felt that they were prepared for their role, whereas in other studies the lack of training and preparation for preceptors and mentors is usually highlighted (Coates and Gromley

1997). The limitations of this study were the small sample size and the use of tools not already validated. Also, limited information was given about the definition of preceptoring (which may be different in Canada to the UK) and there was no information about what training the preceptors had received in the past.

Interestingly Usher et al. (1999) replicated the research by Dibert and Goldenberg, in Australia. Their sample consisted of 134 preceptors working in North Queensland. Their participants had varying degrees of experience of preceptoring newly-employed or new graduate nurses. Generally, the results in Usher et al.'s study parallel those of the original study. However, there was a lower correlation coefficient in this study, but this could be due to the size of the sample being larger resulting in lower probability. A major difference in the second study was a reference to material and non-material benefits, which were not distinguished in the first study. It is not clear from the study what was meant by material and non-material benefits and whether this includes financial benefits. A limitation of this study is the substantial difference in the experience of the preceptors with both new graduates and newly-employed staff. It would have been beneficial to compare these differing levels of experience to confirm Dibert and Goldenberg findings with respect to the correlation between the levels of commitment to preceptoring and the extent of an individual's experience of preceptoring.

In dietetics, preceptoring is a new activity to support and help with student learning. Unlike nursing where preceptorship is for newly-qualified staff, in dietetics preceptorship is used as a means of helping students to learn skills, behaviours and attitudes for future professional practice (Gates 1995). Mentoring is not a term that is used but the concepts and aims given for preceptoring in dietetics are similar to the aims of mentoring in other professions. Gates (1995) suggests that, although dieticians recognise that part of their professional responsibility is to help prepare the next generation of practitioners, there are factors that inhibit them, such as time. The approach used in dietetics encourages the observation of preceptees with the aim of assessing performance, followed by

reinforcement of appropriate behaviour or constructively criticising inappropriate behaviour.

In medical literature there are many inconsistencies in respect to the concept of mentoring and its implementation. There are relatively few research studies on the topic because of its newness to the profession and, as with other healthcare professionals, mentoring is used in different contexts. It is sometimes seen as a support structure for new practitioners, without formal assessment (Connor et al. 2000, SCOPME 1998), or as a method of teaching medical students, which sometimes involves the assessment of skills (Ricer et al. 1995, Flach et al. 1982). It may also be for the purposes of professional development in specialised areas like general practice (Benson et al. 2002, Freeman 1998, Alliot 1996). Regardless of the way mentoring is used in medicine, there are some key attributes associated with the aim of providing support to newly qualified professionals, such as, enhancing professional satisfaction, reducing stress and enhancing professional learning, which appear to be constant.

Mentoring in academia has also been investigated. A study by Benson et al. (2002) examined whether a voluntary mentoring programme could be established with minimal resources that could be effective in the context of major organisational change. The study involved the preceptoring and mentoring of junior academic staff by more senior staff over a number of years. A total of 20% junior staff and 30% senior staff participated in this programme with the evaluation consisting of pre-programme questionnaires, analyses of goals set by mentees and telephone interviews at six and eighteen months. Junior staff rated the mentoring functions very highly, especially the psychosocial aspect, e.g. counselling, role-modelling and supporting. The study also demonstrated the benefits for the professional development of the mentees, particularly where the relationship continued over a long period of time. In addition, participants found the time and resources invested in the project to be worthwhile, as the outcomes for both the individual and the organisation were positive, such as, improved productivity and retention.

Although the programme was positively evaluated, it was difficult to obtain adequate details of the study, such as the methodology, from the article to make an informed judgement about the findings and conclusions. The number of participants was small (approximately 50) for the type of statistical test carried out. Also, Benson et al. used a two-tiered programme, with some junior staff being completely new to the department and some having spent a considerable time in the department. This meant that the mentees had different needs at each stage, resulting in the mentors/preceptors having slightly different roles. However, the data collection and analysis remained the same, which may not have been appropriate since different factors needed to have been measured at each stage.

The literature on mentoring from other disciplines was also explored and read. The above examples demonstrate the diverse use of the terms mentoring and preceptoring and how the aims and objectives of each can vary depending on the professional background. This makes it difficult to compare studies or form conclusions. Also much of the literature on mentoring from other disciplines was not relevant to health care. For example, in academia/education, mentoring can happen easier due to logistical issues, where the mentor and mentee are in the same area and work the same hours. However, from the literature examined it appears that the main purposes for mentoring can be grouped into three areas: learning, support and development (Wilson 2004, Waters et al. 2003, Bleakley 2002, Hutton-Taylor 1999, Freeman 1998, SCOPME 1998, Neary 1997, Cahill 1996, Sachdeva 1996). Freeman (1997) describes holistic mentoring as an intervention that holds together the three parts to mentoring: continuing education, personal support and professional development. The mentoring relationship and the benefits of mentoring extend to both the mentor and mentee. Although mentoring is perceived as a system that benefits the student or new member of staff, it does in fact have advantages for the mentor, with regards to their continuing education and professional development (Cahill 1996, Sachdeva 1996, Ricer et al. 1995), as well as for the organisation involved (Benson et al. 2002).

2.4.2 Obstacles to mentoring

Like any idea or activity, mentoring has challenges that impact on its usefulness and the experiences of those involved. The number of mentors available, the mentors' workload, the training of the mentor, the disparity of duty rosters for mentors and mentees, and above all the supportive culture of the practice settings affect the outcome of the mentor/mentee relationship. Problems in these areas, along with other factors such as lack of time and individual willingness and commitment, can mean that the mentoring process is not an effective one, with few positive outcomes for the individuals or the overall provision of care.

The retention and shortage of trained and experienced staff is a major inhibitor of mentoring (Hindebrandt 2001, Bick 2000). Studies suggest that difficulties in retaining staff relate to dissatisfaction in practice and the desire to move to somewhere more suitable (Harvey et al.1998). Hence, having a mentoring system at all levels of practice would provide the support and training needed to make a practitioner's job more satisfying. Also, the inability to retain staff results in shortages, particularly at senior levels. This in turn has implications for the support, training and assessment of students and new staff (Bick 2000).

There have been a number of studies conducted in the area of mentoring, but according to Cahill (1996) there is still little evidence of the effectiveness of mentoring as either a support system or a clinical teaching strategy. As far back as 1996, Cahill suggested that this could be attributed to the lack of understanding of the role of mentors, the variations in the level of support provided by each mentor, the difficulties in building a supportive relationship and the need for mentors to have a support system as they take on their role. However, little appears to have changed, with the same challenges remaining (Wilson 2004, Usher et al. 2002, Hardyman and Hickey 2001, Andrews and Chilton 2000). A number of studies have highlighted many obstacles that compromise the effectiveness of mentoring. Cahill (1996) conducted a small qualitative study using discussion groups and interviews with final year registered general nurse students. This was a small, non-representative study based at one specific Trust and therefore cannot be generalised. However, the findings were informative. The study found students to

be critical of mentoring for many reasons, such as mentors having limited understanding of their role. This has also been found in other studies (Hardyman and Hickey 2001, Andrews and Chilton 2000, Kiviani and Stillwell 2000). Lack of preparation and absence of a coherent support structure for mentors was another area of criticism, which has been echoed in other studies (Hardyman and Hickey 2001, Andrews and Chilton 2000, Bizek and Oermann 1990). Finally, the need for a clear definition of mentoring within the clinical area was identified.

An evaluative study by Kaviani and Stillwell (2000) was based on a 100-hour long preceptorship programme, developed and delivered by a nurse education institute in consultation with a healthcare organisation. The aim of the programme was to aid registered nurses in effectively integrating, assisting and supporting the development of clinical competencies of undergraduate nursing students. Using evaluative research methods (focus groups and individual interviews), they examined the views of preceptors, preceptees and nurse managers about the preceptor role and factors that influenced the performance of preceptors. Based on their findings, Kaviani and Stillwell assert that teaching and clinical supervision are skills that need to be developed, and it cannot be assumed, by virtue of a person's knowledge and experience, that they can automatically function as an effective preceptor or a mentor. This is a problem since most preceptors are chosen because of the number of years they have been in practice rather than for their skills. Kaviani and Stillwell, like Cahill (1996), also acknowledged the need for support of mentors, which is not normally available. They stress that workload and mismatch of duty rosters affect preceptorship programmes, preventing the two parties from having opportunities to work together or having time to develop a relationship. Although this study was useful in identifying some of the obstacles of preceptorship programmes, and made recommendations for their implementation, it did not contribute any new ideas or suggest any concrete practical actions to ensure the success of such programmes.

Studies by Usher et al. (1999) and Dibert and Goldenberg (1995) found that a lack of support for the preceptor to carry out their duties can be an obstacle, and that commitment by a preceptor to a preceptorship role is positively associated

with the level of support they themselves receive. In their study, Usher et al. used a convenience sample of 134 nurse preceptors supporting a third year clinical elective of an undergraduate nursing course. These nurses were recommended by their administrators and did not volunteer for the role. The sample being selected in this way is likely to have had a major impact on the findings of the study. It could be argued that individuals were chosen because of their positive views on preceptoring, which may have biased the findings. Alternatively, because they did not volunteer, they may have become hostile towards the study and provided negative opinions. Therefore, voluntary participation or random selection may have allowed for a more unbiased response. Also, this group was found to contain a relatively large number of novice preceptors. This may also have affected the findings because veteran preceptors would have more experience to draw upon.

A mixed method study by Coates and Gromley (1997) involving preceptors, nursing students, ward managers, senior nurse managers and nurse teachers highlighted both the benefits of, and hindrances to, preceptorship programmes. The aim of the study was to explore the views of all the above mentioned participants about preceptorship. The initial phase consisted of data collection through questionnaires for the preceptors, followed by group interviews with students and teachers and then individual interviews with the rest of the participants. Criticisms of this study include the low response rate for the questionnaires, the possible bias of a convenience sample and the use of an invalidated tool. Although the questionnaire developed for the study was piloted, it could have been further strengthened if psychometric testing of the research instrument had been carried out. The findings identified some perceived problems with working as a preceptor, such as lack of time, workloads, shift patterns, staff shortages (including skill mix), and lack of knowledge and training for preceptors. These hindrances are not unique to preceptoring but affect all aspects of healthcare, from student support and teaching, to staff development and patient care.

Most studies on preceptorship and mentorship identify similar obstacles to those mentioned above. Based upon the review of the literature, it has become

clear that, although obstacles were identified, no study was able to outline satisfactory approaches to overcoming these obstacles. For example, according to some studies, lack of time was a factor that inhibited the success of a mentoring programme. However, none of the literature examined in this review explored exactly how much time mentoring took out of a senior mentor's working life and how this impacted on the organisation, or whether the time spent mentoring actually benefited the organisation in terms of junior staff being more confident, efficient and competent than if they had received no support from a mentor. Overall, the obstacles to mentoring included a lack of role clarity, experience, training and support for mentors, as well as lack of time and additional work pressures preventing quality mentoring opportunities.

2.5 Final summary

In conclusion, it is clear that newly-qualified staff experience considerable pressure at the start of their professional careers and that the need for support, supervision, training and teaching is crucial. Attention to addressing this need should be a requirement by all governing bodies. Mentoring by senior members of staff has been identified by both nursing and midwifery as a means of addressing this need. Since the call from the Government is for a closer working relationship among healthcare professionals and a more collaborative approach to healthcare delivery, strategies for healthcare improvements need to consider an interprofessional dimension.

Although much research has been done on mentoring and the concept of interprofessional working and education, substantial methodological problems limit their usefulness. No operational definition of interprofessional working exists, making it difficult to compare studies or to draw inferences from the findings. Also, the absence of a theoretical framework to guide research makes any investigation into mentoring or interprofessional working challenging.

In examining the literature, a gap clearly exists around interprofessional approaches to the mentoring of newly-qualified staff. Although a project at the

Mid-Essex Hospital Trusts involved senior nurses mentoring PRHOs, the project was short-lived and no strong conclusions were drawn. Also, this study and its findings were not disseminated effectively, thereby not allowing others to have the opportunity to examine the impact of such a project. The need for further work to explore interprofessional mentoring is therefore clearly evident. The aim of this study was to examine the perceptions of both mentors and mentees involved in an interprofessional mentoring project.

Chapter 3

The Research Design

The purpose of this chapter is to provide the rationale for, and details of, the research design. According to Allen et al. (1986), the success of a study in answering the research question is dependent on using the appropriate methodological approach. The aim of this study was to examine whether an interprofessional approach can support newly qualified healthcare staff in their journey to become a practitioner. The approach used was the mentoring of junior staff from one professional group (doctors) by senior staff from another (nurses). This study focused on the meanings people gave to their experience of mentoring and being mentored and its influence on their practice and their working environment. Latimore (2003) suggests that *'if a researcher is to understand social phenomena, he or she needs to discover the participants' definition of the situation, that is their perception and interpretation of reality and how these relate to their behaviour'* (p81). This was the specific aim of this study, viz., to discover the reality of mentoring for the participants and its impact on their practice and their working relationships with other healthcare professionals.

As aforestated, the settings for this study were four NHS Trusts across the South West of England. As an outsider to each setting (not being employed by any of the Trusts), I wished to use a methodological approach that would provide the richest possible data and the greatest insight into the phenomena under investigation. This study was concerned with the meaning and interpretations which participants gave to their experience of interprofessional mentoring and how they believed it influenced and shaped their practice. It was necessary to get into their world of practice and this required the most appropriate method of data collection.

The objectives of this study were to explore the merits and demerits of an interprofessional approach for the support of newly qualified healthcare staff as they embarked on their practice, as well as to gain an insight into the experiences of both the mentees and the mentors. The approach used was the

mentoring of junior doctors by senior nurses. The following research questions for this study were formulated:

1. Of what benefit is mentoring for newly qualified doctors?
2. Can one profession mentor another?
3. Can a senior nurse contribute to the personal and professional development of a junior doctor?
4. Do mentors benefit from the experience of mentoring junior staff from a different professional group?
5. What influence does an interprofessional approach to mentoring have on the working environment?

As a result of the research questions the study became one of human actions, interactions and perceptions. In addition the study involved the bringing together of two cultures, nursing and medicine. Arguably, ethnography is the best methodological approach for examining patterns of behaviour that shape cultures (Roper and Shapira 2000, Agar 1986). One of the major characteristics of ethnography is 'thick description' (Geertz 1973) that makes explicit the intricate patterns of cultural and social relationships. In this study, there was a need to identify and describe the complex issues around interprofessional mentoring. A thick description of mentoring and the experiences of it were more important for this study than the generation of theory (as in grounded theory) or discovery of the essence of mentoring (as in phenomenology). Therefore, an ethnographic approach was used to examine the experiences of those who were involved in interprofessional mentoring, which was a new cultural activity for both professional groups.

A structured interprofessional mentoring scheme was new to participants in each of the four Trusts. It was, to a great extent, removed from the cultural setting they were used to and trained to expect. Examination of interprofessional mentoring inevitably involved an analysis of the culture of the professional groups and the organisations in which they practise. Therefore, it also became a study of the culture of the participants, their reaction to cultural change and the way they interacted with each other. Of course, cultures are not homogeneous; people are located in a different place in each culture and there may be conflict between cultures or even within one culture. As a qualitative research methodology which aims to study the culture of a group (Brewer

2000, Hammersley and Atkinson 1995, Patton 1990) ethnography was deemed the most appropriate methodological approach for the study since there was a need to examine how mentors and mentees perceived their experiences, and how they felt mentoring influenced their own practice and the practice of others with whom they worked. Further, it was necessary to gain insight into the effects of interprofessional mentoring on the working environment and the professional practice of the participants; an ethnographic approach was apposite as it allowed for mixed methods of data collection.

In addition, ethnography crosses the boundaries of both positivism and interpretivism (Brewer 2000). Within the interpretive paradigm, human actions are seen to be the result of social meanings such as beliefs and values rather than a simple causal relationship or universal law. According to this viewpoint, people interpret stimuli and respond to them accordingly, which can change with time and other stimuli (Hammersley and Atkinson 1995). It is a search for the meaning people attribute to their actions, the essence of their experience and the natural unfolding of real life events (Patton 1990). In this paradigm, it is important that what is being studied is examined in its natural setting. Since both the effects of interprofessional mentoring in the practice area and the individuals' interpretation of the influence of mentoring on their work were important, an interpretive approach emerged as the most fitting for this study.

It was not possible to entirely distance myself from the field of enquiry. My background as a nurse, with 15 years of experience of the cultures under investigation, particularly the nursing culture, influenced my thought processes and decisions about the study. Contact with the participants and the researcher's presence in the setting inevitably affected the study. This interactive relationship was acknowledged at the outset of the study. Davies (1999) agrees that '*reflexivity expresses researchers' awareness of their necessary connection to the research situation and hence their effects upon it*' (p7). I ensured I was aware of my effect on the study and the research process and did not allow any personal prejudices towards the medical profession or preference for any particular nursing theories influence the study.

Another influencing factor in the choice of methodology was the history of research. The positivistic paradigm and methodologies have dominated the medical profession, and the nursing profession, in turn, has been influenced by

the medical model, particularly in research activities (Cushing 1994, Doering 1992). Overtime it has become clear that questions arising in nursing practice cannot always be answered by quantitative methods and consequently the use of qualitative approaches in developing nursing theory and knowledge has increased and become more acceptable (Munhall 2006, Holloway and Wheeler 2002, Morse and Richards 2002, Holloway 1997, Morse and Field 1996, Clarke 1992). Therefore, an ethnographic approach, which allows the use of both qualitative and quantitative methods of data collection, was adopted.

3.1 Ethnography

Ethnography is primarily about the study of people, their patterns of behaviour and the meaning they give to their lives, all of which form their culture (Bernard 2002, Roper and Shapira 2000, Lecompte and Schensul 1999, Agar 1986). There are many definitions of culture, which can be summarised as patterns of behaviour and beliefs adapted by groups of people that continue overtime. Helman (2001) defines culture, as a set of guidelines inherited by members of a particular society, shaping their view of the world and its emotional experience, which influences their behaviour towards other people, the environment and supernatural forces. Medicine and nursing each have long-established cultures which, although intertwined, are still quite separate and distinct. The concept of culture and power within health care has long been debated. Wicks (1998) wrote about the complex relationship between nurses/nursing and doctors/medicine. She noted that, within the healthcare setting, it is possible to observe the power differences and behavioural patterns that exist between the members of an organisation. From personal experience of working within the NHS and being part of the workforce, I too had similar observations. As a junior nurse I learnt that a culture of hierarchy existed within my own profession, as well as in other professional groups and within the healthcare organisation, and that each professional group was portrayed with certain characteristics which shaped my view of them. These contributed to the way I interacted with other healthcare workers. For example, I rarely had any contact with consultants who appeared to be so much more knowledgeable

and powerful. This was due to my own perceptions of with whom I should have contact and the way the ward functioned. For example only senior nurses carried out consultant rounds or communicated with senior doctors because of their experience and their grade. This pattern of behaviour was also reinforced by more senior nurses on the ward.

There are two distinct cultural aspects to this study. First, health care has a culture of its own; second, even within the culture of health care, each professional group appears to have its own culture. For example, within the nursing profession, mentoring is an acceptable phenomenon that is very structured and incorporates the assessment of competency. However, in the medical profession, mentoring is a fairly new concept and is seen more as a form of support with no judgement of professional skills and is not yet an integral part of medical practice. Although mentoring does occur within medicine, it is done in an informal and undefined way unlike nursing where individuals are given named mentors. By using an ethnographic approach, it was possible to explore all the cultural variations (professional and organisational) within the setting of the study.

It is generally accepted that nursing and medicine each have their own culture and identity, which have developed overtime, beginning with their training taking place in separate environments. Both the nurses' and doctors' perceptions of interprofessional mentoring, is therefore expected to be influenced to some degree by their cultural beliefs and practices formed during their training and practice. With the use of an ethnographic approach, I describe the patterns of behaviour of individual practitioners as well as whole groups of people, i.e. nurses or doctors, as suggested by Roper and Shapira (2000). The ethnographic approach will aid learning by informing the study about the social and cultural life of the community of nurses and doctors and of the institution (NHS Trusts) (Lecompte and Schensul 1999).

Maggs-Rapport's (2001) review of the literature identified the distinctive features of ethnography, some of which were pertinent to this study:

- **Focus on the meanings people give to their cultural world** – I knew from some initial meetings during the early stages of the study that cultural issues would be raised by the participants because so much of their perception was influenced by their professional background and identity;

- **Researcher as data collection 'instrument', participating in cultural activities** – I was the sole researcher in the study and collected all the data within the participants' working environment;
- **Total immersion in the lives of the research participants** - I spent some time with the participants in various settings to gain more insight into their experiences to help with the analysis of the data. However, I had been immersed in the healthcare culture as a practitioner for many years before this;
- **Concentration on interaction, observation and speech** – although observation was not the main form of data collection, I did try to monitor and study the interactions between mentors and mentees in practice. Notes taken about the interactions witnessed and my personal feelings became useful sources of data, which were analysed alongside the interview data. As mentioned above, I had been immersed in the healthcare culture for many years as a practitioner, which provided me with adequate knowledge of the cultures involved in this study. I therefore did not feel that the study would in any way be jeopardised if participatory observation was not part of the data collection process;
- **Searching for 'rich points' (Agar 1997, p1157)** – as the interviews were being conducted, it became obvious that there was a great deal of rich data that revealed the essence of the nursing and medical cultures and the struggles between the two groups;
- **Description of systems and emergent theory** – through this study I was able to describe the structures required to develop an interprofessional approach for supporting newly-qualified staff and the benefits that this approach had on the working practices of both professional groups.

The development of ethnography has involved immersion in the field, observation of and interaction with participants and long periods spent in the field/study setting (Hammersley and Atkinson 1995). Over the years, the different schools of ethnography have developed the approach to include interviews, as well as open-ended questionnaires as part of data collection (Brewer 2000). In this study, it was deemed necessary and beneficial to use both qualitative and quantitative approaches, hence I used questionnaires as

well as interviews (see data collection). I believed it was important to have views from all those participating in the mentoring scheme. It would not have been possible to interview all 143 individuals involved, but a questionnaire could capture some of their experiences and provide the participants with a chance to share their views.

There are other studies on mentoring, interprofessional working and health culture that have also used an ethnographic approach. Watson (2000) used a mixed method ethnographic study to explore the support that mentors in clinical settings receive and require. Watson used the data from a series of short unstructured interviews with selected subjects to construct a questionnaire. Participants for the interviews consisted of one mentor from each of the wards in the Trust, while the questionnaires were distributed among all the mentors in the Trust. Interviews were conducted until data saturation and the questionnaire was short to ensure maximum participation.

There were important differences between Watson's study and this study. For example, his study was with nurse mentors who were mentoring other nurses whereas my study involved the mentoring of junior doctors by nurses. Also unlike Watson, I collected data using questionnaires and interviews simultaneously, and my study involved four Trusts rather than one; thus taking a broader perspective. Watson failed to explain adequately how his study was an ethnographic study and why the ethnographic approach provided a richer insight than another approach. His findings were, however, interesting, and identified the lack of support for mentors, the need for mentors to spend more time with mentees and the need for Trusts to invest more in mentoring by providing general study leave so that mentors can be better prepared and trained for their role.

Annandale et al. (1999) used an ethnographic case study of emergency health care to explore the possibilities of interprofessional working. The research involved observing two emergency units over a four-month period, consisting of 50 individual cases and 43 interviews in total from both units. The authors did not specify the type of observation carried out. Also the participant selection for the interviews was opportunistic. The information provided about the methodology and the research process was limited. The lack of methodological information is a common occurrence within the literature

published around mentoring and interprofessional working. It therefore became important for me to ensure that this study was clear about the methodology used and its appropriateness to the research question.

3.2 The study setting

Within an ethnographic study, the setting is an important component and, as Brewer (2000) suggests, ethnography is the study of people in their own natural environment using methods that capture their everyday activities and the meaning they associate with the social world around them. For this study, the setting was central because much of the interactions, socialisations and relationships were built and developed in practice, on the general wards. It was, therefore, imperative to be aware of the setting and context and use methods of data collection that captured the most significant aspects. Hammersley and Atkinson (1995) suggest that an ethnographic approach uses methods that take into account the nature of the setting with the aim of describing what happens in it, and how those involved see their own actions or the actions and behaviours of others. Such an approach is generally concerned with finding out how the participants understand their experience, the meanings they attach to events and actions, and the way they perceive their reality.

The setting for this study were the wards within four NHS Trusts across the South West of England where all the participating newly-qualified staff were practising. The practice areas were primarily acute medical and surgical wards in busy general teaching hospitals. The wards were busy with a high turnaround of patients. The speciality of the wards included cardiology, gastrology, general surgery, renal surgery and pulmonary medicine. The wards comprised of a range of staff who were intimately involved in the care of patients on the wards, e.g., nurses, doctors, physiotherapists, occupational therapists and dieticians. Thus a great deal of interaction and communication amongst the various members of the staff was required. The interactions between the mentor and mentee took place in this same environment and contributed to their understanding of interprofessional working and the role of different professional groups.

3.3 Data collection

Data collection in this study involved predominately qualitative methods along with some quantitative methods. Schensul et al. (1999) call for the collection and integration of both forms of data, suggesting that both qualitative and quantitative data can be used in ethnographic research. The ability to use mixed methods of data collection provides the researcher with richer sources of data, from in-depth information on a topic to observation of the situations and events as they happen. Neary (2000), in her study of student support through mentorship, further supports this by suggesting that validity of themes and theories developed from one set of data can be measured against another.

3.3.1 Interviews

Interviews were the most appropriate method of data collection for this study. I needed to explore in depth how new medical graduates felt about starting their first post and how having a nurse mentor influenced their practice and their learning. The experience of nurse mentors supporting junior doctors whose needs may differ to that of new nurses was also important and was examined through the use of interviews (see appendix A for more details on the development and identification of the topic areas for the interviews). A one-to-one interview would allow the participants to share their views and what they believed to be relevant. Also, the interaction between the researcher and the study subjects during the interview could stimulate the sharing of more information. Developing a valid and reliable questionnaire that could generate the same depth of data as interviews would have not been possible. Also, because the response rate for questionnaires is normally low, I believed interviews were the best option for collecting adequate data in this study. Through interviews, I was able to gain an insight into the world of the participants, which might not have been possible using questionnaires. For Van Manen (1990), interviews develop conversational relationships about the meaning of experience and also allow the researcher to collect narrative material to deepen the understanding of the human phenomena under investigation. Interviews allow the participants to share the aspects that they

feel are important and relevant and give meaning to their world (in relation to this study, interprofessional mentoring).

Interviews were arranged at a time and place convenient to the participants (Brewer 2000, Cormack 2000). This occurred mainly before or after their shifts and took place on the wards in a quiet office. From a total of 32 planned interviews only two individuals actually forgot the interview appointment and one individual was ill and unable to cancel the interview in time.

3.3.2 Questionnaires

As one-to-one interviews became an obvious method of data collection for this study, there was a sense that important insights would be missed if not all participants had an opportunity to share their encounters and views, since every individual has their own story to tell. By using a questionnaire, I was able to reach all 143 participants of the mentoring scheme. Self-completed questionnaires were used as they are very efficient in terms of researchers' time and effort (Robson 2002). Questionnaires allowed for the collection of demographic data, and past and present views and experiences of both interprofessional working and mentoring. According to Peat (2001), a well-designed questionnaire can contribute to efficient research and greater generalisability, but a reliable and valid questionnaire takes time and vast resources to test and develop.

A questionnaire was designed based on the literature and the aim of the study. By examining literature on mentoring, preceptorship, medical education and questionnaire design I began to identify the key areas that were important to this area of study. For example, the demographic section was developed to obtain a picture of the history and background of the participants. The other sections were developed partially on the basis of what I wanted to know, such as the stressors and worries of mentees on commencing a new post and the anxieties that nurse mentors had about mentoring someone from a different profession, and partially from what the literature showed in relation to interprofessional working, junior staff stress and mentoring. For example, literature on junior doctors showed that the main source of support for them were other doctors particularly their own peers; hence one of the questions

asked junior doctors to indicate their main source of support (see Q. no. 8, post questionnaire, appendix B).

Although there are a number of questionnaires about the relationship between doctors and nurses and their views of each other, and the readiness of healthcare professionals for interprofessional education (Parrsell and Bligh 1999, Carpenter 1995), there are no questionnaires on interprofessional mentoring. Therefore, as aforementioned, I was not able to find a relevant, validated questionnaire that met the needs of this study and hence a specific questionnaire was developed. The questionnaire consisted of both open and closed questions and included likart scales. The questions were developed based on the research questions and a review of other questionnaires in this area. Once devised, the questionnaire was given to a diverse range of individuals, including nurses, doctors, researchers and statisticians (12 individuals in total), for their comments and recommendations. By distributing it amongst these various individuals it was possible to examine if the questions were appropriate, were easily understood, measured what they intended to measure and were relevant to the various professional groups. Although this study was predominately a qualitative one, the use of a simple questionnaire allowed for all participant views to be collected and added to the body of data that was generated from the interviews. It was a systematic approach to collect information about the effectiveness, character and experience of interprofessional mentoring. As well as capturing the views and perspectives of many it would also identify issues, which might be further explored using in-depth interviews.

The questionnaires contained a mixture of open and closed questions and were distributed to all mentors, PRHOs, project leads, and clinical tutors (69 mentors, 64 mentees, four project leads and four clinical tutors). They were administered prior to the start of the scheme to obtain demographic information about the participants, along with their views about interprofessional working and the scheme in general, as well as the perceptions of newly-qualified staff on starting their first post. Demographic information included items such as age, profession, speciality and years in clinical practice (for mentors). For the second section of the pre-scheme questionnaire, general questions were asked about participants' expectations of the mentoring scheme. The newly-qualified

staff were asked about their anxieties of starting their post and mentors were asked about any concerns of mentoring individuals from a different professional group (see appendix B).

After a six-month period, post-questionnaires were distributed to obtain the participants' views on interprofessional mentorship and its benefits, as well as provide an opportunity to share further information that participants might deem pertinent and useful for the study through the open-ended questions. The post-questionnaire also consisted of two sections; the first being open-ended questions about participants' experiences of the interprofessional mentoring scheme and the level of support provided, and the second being the development of a Likert scale examining the stress levels of newly-qualified staff and factors that contributed to it, as well as aspects that influenced the educational development of the mentees. Mentors were also asked to rate the benefits of mentoring on their work and in the practice environment (see appendix B).

The pre-questionnaires were distributed to all participants at events such as the meeting with PRHOs during their induction week and mentor training days, where time was allocated for questionnaires to be completed and returned. This ensured universal participation and a high return rate. The post-questionnaires were mailed to all the participants and a mechanism was put in place for returning them once completed. Project leads at each Trust had the task of reminding the participants to return their questionnaires.

3.3.3 Observation

Observation of the environment and the participants was a third method of data collection. Ethnography has its root in anthropology and the study of communities and, in the past, anthropologists would spend years living with the communities they were studying. For this study, it was possible to watch and monitor the settings from a distance. For example, I would attend all meetings to do with the study, such as mentor support meetings, joint teaching sessions and management meetings. On a few occasions I was also able to observe from a distance the interactions between mentors and mentees in the practice settings. These were opportunistic, for example when waiting to meet a mentee or mentor for an interview. However, these times spent in the clinical

setting usefully informed the study by contributing important observational data on such things as social interactions.

Schensul et al. (1999) suggest that through distant observation the researchers are able to orient themselves, even at a superficial level, with the places, people, language, social interactions and other aspects of the setting. Junker (1960) explains how three closely interrelated sets of activities (observing, recording and analysis) during fieldwork lead to knowledge. These activities happened simultaneously in this study and any changes needed were made as the study progressed. Observation was a main source of data collection in this study. However, in the process of collecting other forms of data I found myself being in the field (e.g., the wards) and witnessing the activities on the wards and interactions between the staff which became beneficial and provided a context for the data gathered from the interviews and the questionnaires. On reflection, however, a combination of observer and participant roles for the researcher would be beneficial for future studies as this would give more insight into the world of the participants and a better understanding of the meanings they give to their work environment and situation. Roper and Shapira (2000) agree that *'the real essence of ethnographic participant observation is the combination of participant and observer roles'* (p19). However, having worked within the healthcare system for many years and been immersed in the culture, I had some insight into the interactions, beliefs and possible challenges I would encounter (see Reflection chapter).

3.4 Validity and trustworthiness

It was important to ensure that the methodology used within the study was sound and applicable if the findings were to add to the existing body of knowledge on interprofessional working and mentoring. McKenna (1997) suggests that all ways of knowing must be subjected to the rigour and analysis that knowledge requires. Although I used both questionnaires and interviews for collecting data in this study, I decided that the four aspects of trustworthiness, as used in qualitative research (outlined below), would be a

way of ensuring the rigour of the study. This was because the questionnaires had many open-ended questions, which were analysed qualitatively, and the remaining questions yielded mainly descriptive rather than inferential data.

In both quantitative and qualitative research there are issues around validity, reliability and generalisability. However, these terms apply differently in each approach. Reliability (consistency of the research method), validity (appropriateness of instrument in measuring what it aims to measure) and generalisability (being able to apply the findings and conclusions of the study to others in similar settings and populations) are seen as vital in quantitative methods, but within qualitative research they are inappropriate if applied in the same format. In qualitative research, trustworthiness means methodological soundness and adequacy and is made possible through developing dependability (quantitative equivalent of reliability), credibility (internal validity), transferability (generalisability) and confirmability (objectivity) (Riege 2003, Holloway and Wheeler 2002).

Lincoln and Guba (1985) state that if findings of a study are to be dependable they must be consistent and accurate. In this study I maintained dependability in a number of ways. I described (both for the writing up stage and for the participants during the study) the research process and all the decisions I made about the research step by step, so that readers can evaluate the suitability and adequacy of the research. This also allows for similar studies to be carried out easily. Additionally, I wanted all those involved in the scheme to have a voice and express their views. The only practical method for this was through the deployment of questionnaires. However, I did not feel that I would gain adequate insight into the world of the mentors and mentees with questionnaires alone and wanted to conduct in-depth interviews. Alternatively, I could have interviewed every mentor and mentee but that would not have been practical due to the number of individuals involved in the scheme (143 in total). Therefore, by utilising both interviews and questionnaires, I was able to obtain data from all participants and examine some issues in more depth through interviews. Denzin and Lincoln (1994) argue for triangulation of multiple methods and theories, stating that they improve the probability that interpretation will be acceptable, by way of presenting support for each aspect of data collection. Multiple methods of data collection increase the accuracy of

findings by confirming the truth through various data sources and enhance credibility (Appleton 1995, Lincoln and Guba 1985).

I also ensured dependability by distributing the questionnaires amongst experts in the field of research, nursing, medicine and statistics and obtaining and incorporating their opinions, thereby ensuring that the questionnaire was measuring what it set out to measure. The fact that the study was carried out over a six-month period also helped. Following the first round of questionnaires and interviews at the beginning of the study, I began to analyse the data (see section on analysis on page 73). During the second round of data collection (six months later), I was able to clarify or elaborate on some of the findings, which helped to ensure accuracy and credibility. In my own words, I summarised what I understood the participant to be expressing in the interviews and confirmed that I had understood them correctly. In addition, I drew together the main points at the end of each interview, again soliciting verification from the participants that I had understood them correctly. Lincoln and Guba (1985) advocate researchers returning to participants in order to verify the research findings. Even though it was not possible for me to go back to the participants, I believed that by summarising with the participants what they had said during the interviews ensured my interpretation of their comments was accurate. In addition, another researcher analysed sections of the data, which provided a form of peer review of my analysis (Reige 2003).

I believe that the findings from this study can be transferred to similar situations. It is possible for anyone interested in interprofessional mentoring to learn from the experiences of the mentors and mentees, and to apply the aspects that were positive and beneficial in this study to their own practice setting and with other junior nurses and doctors. Also, in comparing the findings with relevant literature on mentoring and/or interprofessional working, it is evident that some concepts are similar and applied in other circumstances and situations within health care.

The final issue of confirmability was achieved as a result of some of the measures mentioned above, such as the use of multiple sources of evidence (Reige 2003) or reviewing some of the findings from the first round of data collection during the second round. Also, in the sections on data analysis and findings, the reader should be able to follow the path I used to arrive at the

themes and interpretations (Lincoln and Guba 1985). I, therefore, acknowledge that I might have made assumptions but I have attempted not to let these influence me. As mentioned before, I had personal experience of the study setting and had been immersed in the culture and environment under investigation. This had the positive effect of giving me some insight into the setting. Arguably subjectivity can become a resource for the qualitative researcher.

3.5 Sample

There were 144 participants in this study (mentors, mentees and individuals involved in setting up the scheme within the Trusts). Participants were from two different professional backgrounds (nursing and medicine) and I was aware that the research approach must be acceptable and understandable to both professions. For mentors, the criteria for inclusion in the project and study were as follows:

Senior nurses with:

- Two/three years post-qualification experience;
- At least one year's experience of preceptorship or mentoring;
- Diploma level in nursing (desirable);
- Some understanding of both nursing and medical training (this was also covered during the mentor training day).

All junior doctors starting their first post in each Trust were automatically included as mentees in this study. A small group of PRHOs on the surgical wards in one Trust were not included because of a lack of nursing staff to act as mentors.

The sample for this study included senior nursing staff who had agreed to be mentors, PRHOs, clinical tutors and project leads who were willing to take part and become involved in interprofessional mentoring and agreed to participate in data collection. The determination of criteria was based on the need for informants to have direct experience of the phenomenon under investigation, which in this case was interprofessional mentoring (Roper and Shapira 2000, Piemme et al. 1986).

The sampling was purposive and the criteria were explicit and systematic, as Hammersley and Atkinson (1995) suggest. According to Holloway (1997), it is not generalisability but the collection of rich data that is important in purposive sampling. Particularly in qualitative research, a small sample of key informants can be more useful to the researcher than a large sample of general participants without specific knowledge of a topic. Patton (1990) asserts that the *'logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research...'* (p169). In the case of this study, the sample consisted of those individuals with firsthand experience of interprofessional mentoring who could share their experiences.

For the one-to-one interviews, I used purposive sampling but randomly selected the participants so that researcher bias could not intrude. Since there were different groups of participants, i.e. mentors and PRHOs, and there were four Trusts, I ensured that there was equal representation from each Trust and from each group. For the interviews, the following number of individuals were selected from each Trust, which included those involved in managing the interprofessional initiative and a proportion of the mentors and mentees in the study:

- Three PRHOs;
- Three mentors;
- One project lead nurse;
- One clinical tutor;
- One post-graduate manager (only for two Trusts).

Total number of interviews conducted was 68 (34 prior to start of project and 34 post project).

The criteria for the questionnaire were the same as the interview, ensuring that those chosen had firsthand experience of interprofessional mentoring. For the questionnaires, a total population sampling approach was used so that all the mentors, mentees, project leads and clinical tutors involved in the project were targeted. Morse (1991) explains that a total population sample is suitable when all participants come from a particular group. In this study, the whole

population had experience of interprofessional mentoring and were therefore classed as one group because of their shared knowledge and familiarity with the area being studied. All those involved in the interprofessional mentoring (143 individuals in total) were asked to complete a questionnaire at the beginning and after six-months of mentoring.

3.6 Analysis

Ethnography is a process and the analysis is simultaneous with the data collection as part of that process. In ethnography analysis can be defined as the process of bringing order to the data, organising it into patterns, categories and descriptive units, and looking for relationships between them. The aim of analysis in this study was to bring order to the large amount of data collected. There was a variety of data available from this study; the questionnaires generated both qualitative and quantitative findings and the interview data consisted of 34 transcripts of one-hour interviews (on average). Other documents, such as notes from meetings between mentors and mentees, were analysed alongside, although only a few such documents were available.

3.6.1 Quantitative analysis

For the questionnaires, descriptive statistical analysis of the quantitative data was conducted using the latest version of the Statistical Package for Social Science (SPSS) version 9 and the results contributed to the description of the participants' experiences and the study setting.

3.6.2 Qualitative analysis

Analysis of the qualitative information was more complex and time consuming. In this study I used a humanistic approach, which meant trying to capture the reality of interprofessional mentoring and accurately describing the experience of the participant. *'Description – in its everyday sense... – is at the heart of qualitative inquiry'* according to Wolcott (1994, p55). The purpose of the analysis in this study was to describe interprofessional mentoring from the perspective of those experiencing it. This process was undertaken systematically and rigorously using thematic analysis.

There are many steps in the process of analysis as used in this study. The qualitative data (from the interview transcripts, open-ended questions from the questionnaires, meeting documents and reflection notes) were firstly organised into an orderly fashion due to the sheer volume of information. Following this, all the data was read and reread so that any patterns could be identified and coded. For example, by reading the first interview and comparing it with the next few interviews, a pattern emerged in respect to junior doctors' fear of the unknown. They were worried about being on call, about being asked questions and about not knowing the correct medication dosages to prescribe. These concerns were a common theme in most interviews and were subsequently coded and grouped together. The next step was to find the idea that linked the different patterns together and place them into categories summarising what the participants were saying. In the example given above, the categories identified were: anxieties of new staff, lack of experience, accountability and responsibility. Next, the broad themes that emerged from the categories were identified. For the above example, the broad theme became 'the stresses and needs of a new practitioner'. These steps were performed throughout the data analysis. Following the description of experiences shared by the participants, I then tried to interpret what it meant for the day-to-day life of a new graduate and those working with them. Through this interpretation it was possible to provide further meaning and explanation (Brewer 2000). Atkinson and Hammersley (1998) suggest that a feature of ethnography is the attribution of meaning to the human actions described and explained by participants while analysing the data. These meanings are then put into context by adding theoretical and analytical aspects. These processes became the next steps in the analysis for this study. To ensure the accuracy of my interpretations, I revisited some of the major findings with the participants during the second round of interviews.

In this study, the presentation of the data appears in two chapters. The first chapter (Findings) contains the data exactly as the participants described it and aims to represent the experiences of the participants as closely as possible to their own words. This gives the reader an opportunity to build a picture of what being newly-qualified feels like and what it would be like to be a mentor or a mentee in an interprofessional mentoring programme. In the second chapter

(Understanding the journey), I present an interpretation of the findings, which was derived from the analysis of the data, and through this a story about being a new practitioner is written. The chapter entitled 'Reflections' can also be classed as a third chapter in the presentation of the data. This chapter is a descriptive reflexive account of the research process, which involved a reflection on the impact of various incidences that did or could have influenced the outcome. These include descriptions of the social setting, the power relationships in the research field, and the researchers' preconceptions and interactions with the subjects. Reflexivity is an integral part of both the interpretation and writing up processes, as attribution of meaning to the data needs to be done reflexively (Brewer 2000).

3.7 Ethical considerations

A proposal was provided for the Chief Executives, Directors of Nursing and Clinical Tutors at each of the participating Trusts, as well as for the Chief Director of the Regional Health Authority. Consent was given for the project from all the above. Since it was the staff experiences of a support mechanism that was under investigation, the Regional Health Authority and the Trusts were happy for the study to be conducted with only the consent of the participants themselves. At the time of my study, Local Research Ethics Committee (LREC) approval was not required because the study did not involve patients. However, due to changes in the guidelines, approval will now be required from LREC for similar projects. The proposal for this study went through the departmental research committee of Bournemouth University for ethical approval. Once the Trusts' Regional Bodies' and university's consent had been obtained, the participants were approached for the study and given written information about its purpose. Participation was on a voluntary basis and the participants were free to leave the study at any time.

From the outset of the study, I had a dilemma about the benefits of the study for practice and particularly for those who took part in the study. Creswell (2003) suggests that researchers need to identify problems to investigate that will benefit individuals being studied. I sincerely believed that,

through interprofessional mentoring, not only would the newly-qualified staff receive support but they would also develop their skills of working and communicating with other healthcare professionals to ultimately improve patient care. Mentors would also gain new skills in mentoring and understanding the needs of and demands on other professional groups. Therefore, I considered that this study would not only provide important findings in light of the interprofessional agenda in healthcare but would also benefit the participants themselves.

My first consideration was for the participants, hence I ensured they had enough information about the study and had access to someone (usually me) at all times to ask questions or share concerns. I wanted to make sure they had enough knowledge about the study to make an informed choice about participating. Once the participants had understood the study and were willing to take part, their consent was obtained in writing for the interviews and was implicit in their agreeing to complete the questionnaires. This was in accordance with research ethics (Creswell 2003). Total anonymity and confidentiality were maintained throughout the study to protect the participants, which is a requirement within the research governance framework (DOH 2001). Contact details, tapes, transcripts and computer data were placed in a locked filing cabinet.

Chapter 4

The findings

This chapter describes the experiences of both mentors and mentees in relation to an interprofessional approach used for mentoring. Through that experience, participants shared personal and professional factors that impacted on their practice, their views and their perceptions about interprofessional working and mentoring. Since both qualitative and quantitative methods of data collection were deployed in the study, this chapter will incorporate the findings from both methods. The findings presented include the data from the interviews, the open and closed questions from the questionnaires and some personal observations. The total number of participants in this study included 69 mentors (senior nurses), 64 mentees (PRHOs), four project leads, four clinical tutors and three post-graduate managers, of which four clinical tutors, four project leads, two postgraduate managers, 12 mentees and 12 mentors were interviewed.

The sheer scale and complexity of the data generated from these sources required a systematic approach to their analysis. According to Brewer (2000), ethnography is a process and not a sequence of discrete stages, and therefore the analysis was simultaneous with the data collection as part of that process. Since the research questions were broad it was not possible to predict what would be found. Therefore, data was gathered on many related topics and once the analysis began it was then possible to discover what was relevant and recurring. Analysis is about bringing order and organisation to data and finding relationships (Brewer 2000), which is the process used in this study. Appendices C, D and E demonstrate the process of analysis undertaken, including the various stages, as well as a summary of the quantitative findings, which utilised SPSS. Following the development of the themes and categories, they were further analysed, condensed and some attribution of meaning was given to them, leading to two major themes: the journey of becoming a professional in relation to self and the journey of becoming a professional in relation to others (see Table 1).

Sub-themes	Themes	Major themes
Educational and professional development of doctors and nurses Stresses and needs of a new practitioner Support structures Benefits, challenges and expectation of interprofessional mentoring	Stress and anxiety of practice Learning to become a professional	The journey of becoming a professional in relation to self
Cultures and socialisation of the professions Experiences and understanding of interprofessional working/education Need for a collaborative team approach	Socialisation into profession and organisation Collaboration to aid practice and become a professional	The journey of becoming a professional in relation to others

Table 1. Main themes and sub-themes identified from the findings

Brewer (2000) explains that in humanistic ethnography the aim is to capture 'the inside', which means understanding what the insider sees as their reality. Therefore, the insider's own words must be used so as to stay true to the findings. For this reason, in the following sections I have tried to capture what the participants shared about their experiences of interprofessional mentoring and their perception of the benefits of such an approach for supporting new staff, as well as its influence on the working environment. To maintain the

integrity of the participants' responses, many of the quotes are taken directly from what the interviewees said. The quotes can be identified by the following codes:

	Interviews	Questionnaires
Mentors	Int M XX*	M XX
Mentees	Int P XX	P XX
Project leads	Int PL XX	PL XX
Clinical tutors	Int CT XX	CT XX
Post-graduate manager	Int PM XX	PM XX

Table 2. Identification of interview participants

* XX denotes the numbers given to each participant and can be seen at the end of each quote directly from the transcripts

The remainder of this chapter will discuss each of the above-mentioned sub-themes in detail with a summary and implications for practice for each theme. Since the focus of this study was about the journey of becoming a practitioner the implications were mostly focused on the influence of interprofessional mentoring on practice. In the next chapter (discussion) I will examine these findings further with regards to becoming a professional in relation to one's self and to others.

4.1 Educational and professional development of doctors and nurses

It was clear from the medical staff interviewed that PRHOs had extensive knowledge of the theory of medicine, which they acquired during their five years at medical school, but they lacked practical medical experience.

> *They learn how to pass finals at medical school and now they're coming out into the real world and learning how to be doctors. It's*

> *a completely different kettle of fish. They've hopefully got a sound theoretical knowledge but need to apply it under pressure, time management, relationships between professions, communicating with patients, making sure treatment plans are effective and are carried out efficiently. Following things through, multi-tasking, all these sorts of things are the sorts of issues that the PRHOs have got to tackle as well as learning how things work at a local level.* (Int CT 3)

Some PRHOs mentioned how they had been '*trained to do everything in a textbook order*' and they stated that practice would be completely different. A few also commented on how, as students, they had no responsibility and that this would change once they started as practitioners on the wards.

> *I think as a medical student you're certainly not expected to take any responsibility.* (Int P 8)

The anxieties expressed by PRHOs with regards to responsibility were closely linked to being and feeling competent at the start of their practice. PRHOs had concerns about being able to carry out the clinical procedures that were required of them. Even though they knew the theory, it was the lack of practical '*hands on*' experience that concerned them, because as practitioners they were fully accountable for their actions. They also felt that other practitioners expected them to be able to carry out clinical activities as a doctor. These issues were not always realised by other health professionals, such as nurses and physiotherapists, who assumed that doctors had the skills as well as the knowledge once they began work in practice. Through their years of experience on the wards, senior nurses were aware that PRHOs are always the first medical staff members to be called on in most instances, despite their lack of practical skills. A few nurse mentors shared their initial shock at finding out how little practical experience PRHOs had.

The experience of mentoring also helped mentors to realise and acknowledge their general lack of knowledge about medical training and PRHOs' ongoing professional development requirements. For example,

mentors knew junior doctors were assessed but where not fully aware of the support and educational structures in place, such as educational supervisors or clinical tutors. Mentors believed that if they had more awareness of what junior doctors had studied in medical school, in particular the practical elements of their training, it would be easier for them to support their mentees and know what clinical experience they needed to gain.

> *I need to learn a lot more about what their backgrounds are, their learning and training. I've learnt quite a bit through doing this job. I mean, I found out a lot of it as I was going along and I think I still need to find out a bit more because even now I am just picking things up from talking to the house officers and I think I need to learn a bit more about what they need to do so that I am there to support them or can guide them if they need it.* (Int M 32)

It became obvious during interactions with the mentors and mentees that they knew very little about the educational journey of the other professional groups. Most PRHOs also commented on their lack of knowledge about nurse training and the roles and responsibilities of nurses. Most did not have much contact with nurses (student or qualified) throughout their five years of university education. There were different degrees of interaction with nurses among the PRHOs. These included one-hour workshops, a day of joint teaching with student nurses at university and a whole day working with a qualified nurse on the wards to gain some insight into their work. However, only a small number of PRHOs became involved in such activities. Of concern was the fact that many of the PRHOs could not even remember much about their educational or practical encounters with the nursing staff, and what little they remembered was not always positive.

Most PRHOs had no idea about what was covered in the nurse training curriculum. As a result, they were unfamiliar with what nurses were able to do in practice i.e. what clinical procedures they were able to carry out. This made it difficult for PRHOs to know what to delegate and what they had to do themselves. This was further exacerbated by the differences in the grades of the nurses and the clinical tasks each grade of nurse was permitted to perform.

I don't know what nurses do and I don't know what nurses know. I've never, in five years of training, known what's on the nursing curriculum. I don't know where the bounds of people's knowledge are. Obviously that's very different for a newly-qualified nurse than for someone who's been working for thirty years on that ward, but it's something which I realise there's this big gap in my knowledge that I don't have a clue really what nurses know and what they don't know. (Int P 8)

I think perhaps the biggest problem is not knowing how much nurses know. They all seem to be different grades and they all seem to have done or know different things and some of them are qualified to do things that others aren't and I find that difficult. Knowing who knows how much and who can do what as well, that's always really difficult to know. (Int P 8a)

It became evident that the participants perceived vast differences between nursing and medical training both at pre- and post-qualifying stages. For post-qualified staff, the learning opportunities varied between the two professions as well as between Trusts. Trusts were obliged to provide weekly teaching sessions (1-2 hours per week) for PRHOs based on a curriculum provided by the Deaneries. These sessions covered general topics and required a 70% attendance by PRHOs. For nurses, there were structures in place for post-qualifying education, but this varied from Trust to Trust and was not always made compulsory by any governing body. Although the Nursing and Midwifery Council (NMC) encourages a preceptorship programmes for newly-qualified nurses, it depends on the particular Trusts as to what they provide as a means of support for such staff.

> *The only requirement is that they must get an hour* [of teaching] *a week and that they have to attend* [these sessions]*; over their year in their PRHO post they have to attend 70% of it.* (Int CT 3)

All participants acknowledged that nurses and doctors learn the basics such as anatomy and physiology. However, the level to which they delve into each discipline is different for each group. An example given was the level of biochemistry that doctors learn about various conditions, whereas nurses concentrate more on patient care and communication skills. One clinical tutor stated that nurses and doctors have a different knowledge base, which leads to different aims. He believed, for example, that medicine was more scientific than nursing.

> *I think, there's no doubt that the medical and nursing professions are coming in with a different knowledge basis and to a certain extent with different aims and that again is something that comes from the training...Doctors still come from a very scientific background, they learn the science and medicine first.* (Int CT 3)

Participants believed that, for the different health professionals to be able to work more closely together, they needed to know more about each other's training backgrounds, with more collaboration in the early days of training and practice. Participants saw the concept of interprofessional education at the onset of training as a constructive move towards better collaboration among health and social care staff. It was felt by some that there were certain core elements in the training of all health professionals, in particular nursing and medicine that could be taught together. This could take the form of joint lectures, so that the students get used to an environment where there are people from different backgrounds, or small groups looking at case studies or problem-based learning. Participants identified an advantage to working in small groups, which was the understanding of the different roles, responsibilities and perspectives of the other healthcare professionals. For example, one PRHO shared his experience of a 'shadowing day' where he worked closely with a student nurse so they could learn about each other's work. The experience for him demonstrated how nurses had developed a perception through their training that doctors just sign forms and prescribe, whereas nurses care for patients. He also believed that doctors develop an understanding of the work of nurses that may not be entirely accurate. This was

demonstrated a couple of times when I observed a mentor teaching a clinical skill to both a PRHO and a newly qualified nursing staff, and how the junior staff were able to discuss issues about the clinical procedure afterwards. Although many participants highlighted some benefits to learning together with other healthcare professionals, one clinical tutor believed strongly that not everything could be taught in an interprofessional manner and that the discipline areas need to be chosen carefully.

> *I think that it would have been worth doing a bit more of this type of thing* [shared learning] *in university but I think now is as good time as any.* (Int P 27)

> *...it's* [shared learning] *something that we perhaps must do a lot sooner in the doctors' and the nurses' training. That is, we start to bring them together a lot earlier so it's not such a culture shock for both professions that they're actually working together.* (Int M 5)

> *Joint training starting earlier on would be one way certainly to do it. Joint generic training on certain things is another way forward. There's no reason why you shouldn't do that. Then that will become part of the norm; that will break down the culture. Start at the bottom and building up.* (Int PM 7)

Summary and implications for practice

All participants were in favour of interprofessional education, which they believed would aid collaborative working and improve the practice environment. It was acknowledged that, although most new staff may have a wealth of theoretical knowledge, they lack practical skills, which they have to learn in the early days of practice. This causes great stress for junior staff who have to deal with their new role as responsible and accountable practitioners.

It was acknowledged that nurses and doctors have different priorities and learning needs and that any initiative would need to identify topics and education methods to suit both professions and ensure that opportunities are created for learning about each other's roles and responsibilities. It was clear

that current pre- and post- registration educational programme provision is varied, which has implications for any interprofessional initiative. In addition, clinical teaching appeared to be opportunistic. This poses the question as to whether the right educational structures are in place to help the development of junior staff.

4.2 Stresses and needs of new practitioners

In this study, the PRHOs that were interviewed expressed their fears about becoming a practitioner. Starting as a junior doctor generated a mixture of emotions, both of fear and of excitement. It was informative to see the differences in the behaviour and attitudes of the PRHOs from the initial interview to the final interview. In the first interviews the fear, uncertainty, anxieties and the sense of being overwhelmed were obvious in both their verbal and non-verbal communication. While during the final interviews I observed a different attitude from the PRHOs; one of confidence, of knowing and a sense of relief, it was clear from the initial interviews that the PRHOs were particularly anxious and nervous about starting their jobs.

> *Total fear I think overrode everything else. I wasn't excited, I wasn't looking forward to starting my first job, I wasn't looking forward to the money, I wasn't looking forward to anything.* (Int P 14)

> *It was just an all-encompassing fear.* (Int P 27)

> *Very nervous.* (Int P 8)

This was further exacerbated by their perceived lack of practical experience as mentioned in the above theme. Most PRHOs acknowledged that they had the theory but putting it into practice was one of their biggest challenges and worries.

> *I think it's also having the confidence to do enough because we know a lot of theory but I don't know whether I've got the confidence to put what I know is right into action.* (Int P 8)

> *Fear of the unknown as much as anything. Fear that I had never really spent that much time on the wards as a student as maybe I should have done and I wish I had done now.* (Int P 27)

Many participants expressed the need for support from senior medical staff. PRHOs were asked (in the questionnaires) to nominate the professional group that supported them most during the first six months of their practice. The results demonstrated that peer support was rated the highest (23%), with senior house officers (19%) and nurses (9%) being the next two groups of professionals who supported PRHOs. A second question supported these findings when PRHOs were asked to what extend different groups of individuals affected their stress levels. The findings showed that the top three groups that decreased their stress levels were senior house officers (74%), senior nurses (70%) and other PRHOs (68%). This was also evident during my visits to the wards where I personally observed on several occasions PRHOs going to senior nurses asking questions about what to do when there were other senior doctors present.

The distress caused by not having this support was evident in both the verbal and non-verbal communication of one PRHO during the interview, to the point where he had already decided to leave the profession at the end of the PRHO year. Having support was very important to all PRHOs, who wanted the security of knowing there was someone they could go to in order to ask questions, ask for advice and receive reassurance that what they were doing was correct and appropriate. Certain times were identified as particularly crucial for receiving support and having someone that they could bounce ideas off. These included the first week of starting their post and when they were first on call for the whole medical or surgical unit and not just for their own patients and team.

Fear of being on call and having no support. (Int P 27)

I think when I'm on call it would just be nice to know that there will be somebody there [for support] *when I've seen a patient. That I'm not there on my own thinking, "Okay so what do we do now and what do I do. I don't really know what to do with this patient". There would be somebody there who I could say, "this is what I think. A m I doing the right thing?* (Int P 8)

Although most junior doctors had anxieties, they were also looking forward to finally having more contact with patients and putting into practice what they had learnt for the last five years. The causes of anxiety commonly identified by most PRHOs were not knowing what they should be doing, having the responsibility of patient care and certain skills like prescribing the right medication and the correct dosage. The findings from the questionnaires also confirmed this, where PRHOs rated responsibility and accountability (85%), workload (83%) and long hours/shift patterns (72%) as increasing stress levels. Most commented on feeling lost, not knowing what their first tasks should be and the need to have someone sit down with them and tell them what they should do first. This has been acknowledged by most of the Deaneries and post-graduate teams at the Trusts.

Other things, such as requesting things, knowing how to get a review of someone, knowing how to get information out of people when you are not sure of something, but after a while you do get there. (Int P 29)

PRHOs believed nurse mentors could help them with organisational issues and basic orientation on the wards such as request forms and daily work routine. They needed to know they could ask someone questions about basic and '*trivial*' aspects of their work without '*feeling stupid*' or '*being talked about afterwards*'. PRHOs did not wish to lose face or show their weaknesses in front of others, particularly their medical team. They perceived that nurse mentors could be the individuals who they could turn to without feeling unintelligent or

belittled. The knowledge and experience of the mentors were seen as useful resources for the mentees. In addition, PRHOs identified areas that mentors were particularly able to help them with, and these included perceived lack of support from others (32%), dealing with patients (26%) and nursing staff (26%).

> *Someone to turn to, to ask "silly" questions.* (P 533)

> *Someone there to ask for help and answer queries no matter how silly they seem, not to be laughed at or talked about even if they are silly or have to be repeated several times.* (P 839)

> *When you first qualify you realise that senior nurses and sisters on the ward have got a great deal of experience and...you'd want to learn from them and often when you start, they're far more valuable in sort of teaching you the little secrets, the little shortcuts, the little nuances which even members of your own team may not tell you, not because they don't want to but they just don't have the time or inclination to do so. So I think that's always happened. But it's just happened in a less formal way.* (Int M 11)

One PRHO mentioned how he hoped to be reminded of tasks he needed to complete before he had to be bleeped by nurses, who on occasions would get cross when routine things had not been done. Interestingly, some PRHOs distinguished between the types of support they could expect from the different professional groups. For example, nursing staff helped PRHOs understand the routine tasks needed to be carried out by them on the wards, whereas senior medical staff were felt to be the best people to consult about the medical management of patients. However, they also mentioned that more experienced nurses helped them with drug dosages or types of test to request for certain patients, which is part of the decision-making process surrounding the management of patients. With this in mind, many mentioned the need for an interprofessional approach to healthcare as each professional group contributes significantly to the care of patients and the development of junior staff.

> ...*They* [the nursing staff] *just suggest because they know what people normally prescribe and even the doses and how many times a day you give it and they were very helpful in that sort of thing*...[Learn from] *everyone, nursing staff and doctors mainly; I mean even today I was talking to one of our diabetic nurses and she was giving me a teaching session on diabetes: quite interesting.* (Int P 29)

Summary and implications for practice

Newly-qualified doctors all had similar anxieties about accountability, prescribing/administering medication, being left on their own and not knowing what was expected of them when starting on the wards. Support in the clinical area and having someone to talk to about fears, worries and practical problems were viewed as most important. In addition, junior staff highlighted the need for being taught the clinical skills they had not yet developed. PRHOs also identified how they gained knowledge and support through their interaction with both nurses and doctors.

It is obvious that new staff receive input into their practice from many sources, including other professional groups besides their own. This, therefore, highlights the possibilities of interprofessional collaboration and the need to explore how such collaboration can be done in a manageable and acceptable way, where the talents and expertise of each professional group are utilised and valued.

4.3 Support structure

All participants acknowledged the need for support structures in practice settings for junior staff and their importance for further professional development. From the interviews it became clear that there was no consensus on who provided the best support for junior doctors but rather everyone contributed in a different way according to the needs of the PRHOs.

Many junior doctors acknowledged the importance of peer support because they believed that their peers understood what they were experiencing, since they themselves were having similar encounters. Mentors and clinical tutors also mentioned that junior doctors went to their peers who were also their friends and shared their anxieties and their experiences within practice. This was also demonstrated in the questionnaires when other PRHOs were rated highest as the source of support for junior doctors (see appendix E). I was also able to observe this when some PRHOs came for their interviews accompanied by other PRHOs and mentioned how they had been having a *'debriefing support session together'*.

> *I don't know, I just feel that most of our support comes from each other* [PRHOs], *because we are going through the same thing. I think someone who is going through the same thing often can be supportive in a way that someone who isn't can't. I think that is where I have got most of my support from; just from peers. You say "I've had a horrible day today and this happened and that happened", and they say "oh yes, that happened to me last week and it is just awful". I think that is the place I have got most of my support realistically; emotional support.* (Int P 8a)

> *I think there are people available for that* [providing support]. *I think the best people are people who actually can relate to you directly and those are the house officers usually. They are a great source of support and people to talk to. You relate much better than having a consultant from the haematology team whom you have never met before really. It is good to have people on your own level.* (Int P 6)

> *He also found support from his peer group.* (Int M 108)

> *Peer support, be it at your own level or at a slightly higher level is hugely important and working in the health service, working with patients, working with all the numbers of members of staff we do, is*

hugely stressful and people do need to just actually be able to talk about that. (Int CT 26)

There were mixed reactions from PRHOs about the extent that nurses could support them. A few felt very happy to go to nurses for any support or advice, while others felt that nurses could only help them within certain parameters. For example, medical management of patients was one area of division. Some believed nurses had the experience to guide them on medical matters, while others were unsure of the nurses' knowledge in this area.

Just everyday things. I feel that I can quite happily go and ask them [nurses] *a thing about patient management even if it was a medical bit of patient management; they deal with it, they've dealt with it. Some of them have worked for ten years on the same ward. So they can tell me what would normally happen in that situation.* (Int P 7)

She could give advice to an extent, but obviously there are big differences between nursing and medicine and things are done in different ways and there are things she can't advise on. (Int P 27)

Many PRHOs commented on how they would turn to senior nurses for information about the right medication dosage or tests and procedures for patients with certain medical conditions. They believed that experienced nurses knew exactly what routine procedures were needed as patients were admitted. I was able to observe this personally when spending time on the wards. It became clear that junior doctors would ask senior nurses (and in many cases mentors) many questions about the routine activities of their work, such as, which forms to fill out, how to refer to social workers or dieticians, as well as what drug dosages to prescribe and routine tests to carry out. They recognised that nurses even knew what each consultant preferred or disliked for their patients, which helped the PRHOs in their early days. The PRHOs attributed this to nurses being on the same wards for the whole working day and knowing the environment, staff and patients well. Some participants concluded that nurses are in a better position to mentor junior doctors rather than vice versa,

since doctors (particularly senior ones) have patients on a number of wards and generally do not spend as much time on the wards as nurses. Hence, they are unable to observe the work of the nurses or develop a knowledge base about their learning needs. In addition to providing information to junior doctors, many PRHOs commented that nurses on the wards were very supportive. A few PRHOs actually received more support from the nursing staff than from their own medical team. Some junior doctors expressed how most nurses did not intimidate them as much as medical staff and did not make them feel unintelligent. Several PRHOs believed that some of their queries could appear *'too simple'* and so by asking nurses they *'kept up a face in front of their medical team'*.

> *I had more contact with the nursing staff. Just the basic things, when you are a house officer, they are a great source of learning yeah. Initially you don't have a clue on how to write up a drug chart and they always help you along with that and often know the doses of drugs which is great. And just sorting patients out socially and things like that.* (Int P 16)

> *So I think that the people that have been really supportive are the nurses. The nurses have got us through the first two weeks undoubtedly...So they really got us through that and just telling us where everything is, what happens.* (Int P 27)

PRHOs explained that they worked within a team, which consisted of an SHO, a registrar and a consultant, and they received support and teaching mainly from members of that team. This was also demonstrated by the findings from the questionnaires. The main groups of professionals who PRHO's believed contributed to their educational development were registrars (64%), senior house officers (49%) and consultants (43%). PRHOs defined their team as being the medical team they were assigned to, but it was acknowledged by many PRHOs that the level of supervision and support received was dependent on the individual members of that team and how enthusiastic they were about teaching, supervising or supporting PRHOs. An additional factor that affected

the kind of support needed by PRHOs was their assessment and registration, as most consultants also acted as their educational supervisors. Educational supervisors, in collaboration with clinical tutors, have responsibility for educating and assessing newly-qualified doctors. PRHOs described how they were always careful and aware of their performance among their team members in case it affected their assessment and registration. A few PRHOs believed that, by showing their anxiety or inability to carry out a medical procedure, it would reflect badly on their assessment. This was why junior doctors liked the idea of having nurse mentors to whom they could turn, so that their educational supervisors would not be aware of their concerns, thus safeguarding their registration.

The level of support received from clinical tutors or educational supervisors varied among the junior doctors. Some PRHOs were fully aware of who their educational supervisor was (usually the consultant of their team), but there were a few who were unsure. Some found their educational supervisor helpful, approachable and always willing to teach and give career advice. Others had difficulty in actually making appointments to see their supervisor for their routine assessment.

> *Well my educational supervisor was my consultant and I have to say there weren't any issues. I easily could have met him if I had needed to in terms of education and often they would be very helpful. Helping us work out where we are going from here, helping with CVs and things like that. That's more from an educational point of view. In terms of if things had gone wrong and I needed a port of call, I could have gone to him no problem but there haven't been any issues where I felt that I specially needed to.* (Int P 15)

> *I don't know* (who my educational supervisor is). *Nobody's told me, I haven't been able to find out. It might well be my consultant.* (Int P 27)

It was apparent that the support received was also dependent on the individual person rather than just on their profession. Some nurses were very good at teaching and supporting and generally working and communicating with other professionals, while others were not. It appeared that the senior nurses with more experience were able to help junior doctors better. This was also true of doctors. Some PRHOs mentioned how their senior house officer, registrar or consultant was good at giving information, teaching and being available and approachable when they needed them; but equal numbers also reported a lack of support from senior medical staff. PRHOs identified those who they felt were trustworthy and understanding and approached them for support regardless of their profession. My own personal experience of observing the senior nurses affirmed this. The mentors which I believed to be more experienced and approachable were the same ones that PRHOs talked about during their interviews and the same ones that I observed on the wards being utilised more by junior doctors.

> *The nurses that are good are fantastic and they make your life easier by miles and miles. They can advise you on what they think is going on and they have got incredible information that you need and it is fantastic. The nurses that are not good, they are a nightmare, particularly on call when you are bleeped by people, you really need somebody who is sensible and who is ringing you up for a good reason. Otherwise you don't know whether your patient is really sick and about to snuff it or he is fine until in an hour when you have finished the other things you have got to do.* (Int P 8a)

> *I have had one registrar that has been approachable and one that has been hopeless. My consultant was very unapproachable.* (Int P 8)

Summary and implications for practice

It was evident from the interviews that support for junior staff comes from a variety of sources and is dependent on the experience and personality of the individual providing the support. Support is also dependent on the opportunities provided by the working environment, for example, nurses and junior doctors spend more time together on the wards than consultants and junior doctors. Therefore, it could be argued that no single profession can provide complete personal and professional support to junior staff and that there is a need to find a way for the different professions to complement each other's qualities. The findings in this section provide an example of the interdependency of the two professional groups and establish a sound argument for interprofessional opportunities within the practice setting.

4.4 Expectations of interprofessional mentoring

Although nurses had always helped junior doctors in the early days of their practice, interprofessional mentoring was perceived as something new when it was arranged in such a formal way. In my own experiences as a senior nurse on the wards I had guided and supported many new doctors on the wards. All participants believed that the mentoring programme was a great idea in theory, and were interested to see whether it would work in practice. Expectations about the mentoring programme varied between the participants, not only between the professional groups but also between members of the same group. For example, some PRHOs did not want formal meetings with the mentors but would rather see the mentor as and when they required. They believed an informal procedure would be more beneficial for them. Others preferred a formal approach, requesting meetings with a set agenda. As a new concept there were no set roles as to the way the mentoring relationship should be developed. It was suggested that formal meetings between the two parties be arranged but it was not an absolute requirement for the project.

Even though nurses were identified as a source of support, some PRHOs were unclear about the exact role of a nurse mentor and what could be gained from the relationship. There were some uncertainties among a few PRHOs

about the parameters of support that would be received from different individuals such as educational supervisors or nurse mentors. However, PRHOs accepted the project as a good idea, which if organised effectively, would lead to improved communication, better understanding and respect for fellow colleagues, less initial anxiety for newly-qualified staff and a bridging of the gap between nurses and doctors.

> *Sounds like a brilliant idea as I am a bit worried about finding a mentor on the ward. So I am glad it's well organised and I can be in contact often.* (P 215)

> *I think it's a great idea, thank you. People to turn to, support and guidance with a smile.* (P 229)

Although many PRHOs identified nurses who were approachable to turn to for help, they found having a named individual valuable and practical. They believed that this individual would '*take them under their wing*' and be '*someone on their side*'. PRHOs believed that those senior nurses who willingly took on the responsibility of being a mentor in this study were obviously prepared and eager to look after newly-qualified staff. Most participants acknowledged that mentors should have the right qualities and training, but should also want to voluntarily take on the role because they enjoy teaching and supporting junior staff. For this study, most of the mentors volunteered but, due to the large number of starting PRHOs, some nurses were asked to act as mentors even though they had not personally come forward. This meant that some were not very enthusiastic about the extra responsibility. This was evident in their interviews where they mentioned the extra workload for the nursing profession in taking on the mentoring of doctors and conveyed their disappointment in the medical team for not contributing to the scheme by acting as mentors for junior nurses. I was also able to observe this during my time on the wards where these same nurses were reluctant to stop what they were doing to answer questions from PRHOs. This response could also have been due to the general attitude of those nurses towards the medical profession rather than just mentoring.

> *Feedback out of it is – it is all right nurses mentoring doctors, but when will you get doctors mentoring nurses? It is supposed to be a two-way thing,* (Int M 10)

Mentors had mixed views about interprofessional mentoring but were generally positive about the project and believed it to be a good idea from the start. Some mentors had anxieties about their ability to mentor a PRHO and what they could help them with, but this pertained mainly to the less experienced nurses who had been chosen, i.e. E grade nurses. Nurse practitioners, ward sisters and more experienced F grade nurses, on the other hand, were generally more confident because they already had mentoring experience with nurses and had worked closely with PRHOs on other occasions. Some mentors were also anxious about the reaction of junior doctors to having a nurse mentor. Like PRHOs, nurses anticipated that the project would improve working relationships and communication among doctors and nurses and allow each professional group to become aware of the role and responsibilities of the other.

> *I think it is an excellent idea – and hopefully will help professionals to work together more effectively.* (M 411)

> *I feel this is an excellent opportunity to improve the working relationships between the two professions.* (M 412)

> *Very good idea. Anything to improve working relationships amongst other professionals, respect, appreciation and understanding of roles – in the long term, enhancing patient care.* (M 101)

Mentors had specific requests and needs as they embarked on their role with the newly-qualified doctors as demonstrated in Table 3 below.

Needs identified by mentors	**No. of mentors**
Ongoing support	15
Sufficient time for mentoring	7
Guidelines for their role	5
Examples of what situations might arise and what information PRHOs might need	3
Enthusiasm from other staff regardless of their involvement in the project	3
Knowing the mentees' expectations	2
Knowing who they need to go to for advice	2
Feedback about their mentoring	2
Encouragement	1
Supervision	1
Information about medical training	1

Table 3. Needs and requests of mentors

Most mentors anticipated that their role would be a supportive one and that they would need to be approachable, good communicators, enthusiastic and able to instil confidence through their experience, knowledge and teaching efforts. A few mentors mentioned how they would have to provide constructive advice and one highlighted how this advice would come from their own experience of being a junior member of staff.

> *In terms of the newly-qualified, I think the advantage is that you've been there yourself not that many years ago and experience is a great asset, and by pointing out potential pitfalls, by sharing in their experiences you can just be a sounding board but you can also give constructive advice as well on certain issues.* (Int M 11)

Although all agreed that the role of the mentor for this project would be to listen, give general advice, be more familiar with the environment and the functioning of the organisation and support mentees, they acknowledged that there may be times when issues would need to be passed on to someone more appropriate and able to deal with them. This was a major concern from the start of the project in that mentees had to appreciate the remits of the different support structures in place for them, as did the mentors, in order to be effective in supporting the junior staff. For this study, the range of activities was clearly set out for mentors and is shown in Table 4 below.

Support newly-qualified staff particularly in the first few weeks of practice
Familiarise new junior staff with the working environment and the functioning of the organisation and ward
Listen to their concerns and needs
Where possible, create a learning environment for junior staff through demonstrations of clinical skills
Create opportunities for collaboration between the junior nurse and doctor
Identify when the health of the junior staff or their patients is at risk, to deal with the situation or pass on to an appropriate authority. (A guideline sheet was given to all mentors and mentees about the structure in place, see Appendix E)
Be able to direct a PRHO to another individual for support or advice if the mentor is not qualified to help, e.g. ask the PRHO to see a clinical tutor or educational supervisor

Table 4. Role of mentors for this study

Summary and implications for practice

In general, both mentors and mentees had similar expectations about the project. The concept of mentoring was new for doctors but senior nurses had the experience of mentoring junior nurses and were able to make it an effective encounter. The PRHOs believed that having nurses as mentors would help them because nurses were generally known to be a resource for new staff. Mentors identified certain requirements that would assist them with their role –

there was a clear need for guidelines about the role of the nurse mentor that should be made available to all participants.

Support from senior nurses for junior doctors has occurred informally for decades. By having such schemes as interprofessional mentoring, there will be more structure for this informal activity, which will ensure that all PRHOs have access to this support rather than leaving it to chance. In addition, formal interprofessional mentoring provides an opportunity for closer working relationships and a better understanding of others' roles and responsibilities.

4.5 Perceived benefits of interprofessional mentoring

Although some of the sections in this theme may sound repetitive, I feel it is important to reiterate certain points. This is mainly because most of the benefits shared up to now have been what the participants predicted rather than experienced and came primarily from the pre-interviews and questionnaires. The discussion to follow, however, is based on the data collected after interprofessional mentoring began. It is interesting to discover what outcomes were anticipated by the participants and what actually occurred.

After six months of the project, most participants accepted that interprofessional mentoring was a beneficial and an essential programme both for the support and development of newly-qualified staff and for the working environment. The vast majority of PRHOs appreciated having a named person who was experienced and knowledgeable to whom they could turn for support, advice, encouragement, teaching, and pastoral and educational issues. The PRHOs were reassured by having someone there if they needed them, who noticed when they were stressed and who watched over their activities to ensure that patients were safe.

> *It was just nice knowing she was there for me.* (Int P 8)

> *Yeah I think it was a good idea having a bit of support, somebody with an outside view.* (Int P 27)

> *I think it was my role to be a little bit more visible to them saying are you okay, is there anything I can do, and if they say no, to go away then.* (Int M 21)

It was acknowledged by many of the participants that the first few days and weeks are the most stressful for new staff. It was, therefore, during the first three months that the most support was required by new staff. Many of the PRHOs found that they used their mentor more in the initial days, particularly with general organisational information, such as useful telephone numbers or forms to use, which made the working environment more manageable and tolerable for them. As they gained confidence and experience, they did not need to use the mentor as much. PRHOs recommended protected time to be set asife for interprofessional mentoring to ensure that they were able to meet with their mentor.

> *I thought it was a good idea as soon as I heard it really. I think I probably said to you before, it was more useful in the early days when you're first setting out, which is obviously the point of it really. I'd have liked to have seen her* (the mentor) *earlier, like in the first day or two...* (Int P 27)

> *I probably asked many more things at the beginning than I did later on, but as time went by it became less and less necessary really. It was mainly routine stuff.* (Int P 29)

> *In the early days she* (the mentee) *might have felt it was nice to have somebody she could go to but she really is a very bubbly, very friendly, very competent, confident person.* (Int M 13)

> *I was able to reinforce information about services like community physiotherapist and other things of benefit, give useful bleep numbers, show him some useful clinical tip. He said he found it very useful to know there was someone around if he needed it.* (M 104)

> *Perhaps having a formal time set to discuss things with your mentor...would be useful.* (P 537)

> *The only way to make the scheme work effectively is to have an allocated set time when nurse/doctor have to meet. During the working day, when busy there is no time, but if this time was enforced then you would have to find the time.* (P 1120)

The PRHOs felt strongly that having a mentor from a different professional group contributed significantly to their initial clinical practice and that it was more beneficial to turn to a nurse mentor instead of a senior medical colleague when they were unsure about an aspect of their work. A clinical tutor also believed that house officers would find it advantageous to confide in a nurse mentor at times rather than their medical team. A few participants reported how nurse mentors had protected PRHOs from senior medical staff and had defended their actions. An additional bonus in having a nurse as a mentor for the PRHOs was the opportunity to gain insights into the work, role and responsibilities of nurses. This was also observable on the wards when junior doctors, after a couple of months of practice, would instinctively turn to certain nurses (mainly senior nurses) with questions about patients or elements of their work.

> *...there are things that they wouldn't* (ask a doctor) *and that they would actually feel much more comfortable asking a senior nurse colleague about because they don't lose face in the same way and they feel they could perhaps be a bit more honest. When they first come out they're very anxious and they don't know what they don't know, and it's that level of support and nurturing and a bit of mothering that goes along with it, and I think from the house officer's point of view there are huge benefits in that relationship.* (Int CT 3)

Well, I mean that could be quite useful. Yeah just from the point of view of seeing where each profession is coming from. I think it is good – anything that increases it, gives you more chances to talk about how your work is useful...I think it was great having a nurse mentor; she's very, very friendly, very approachable, has helped me out practically on a couple of occasions which has been really great... she happened to be around and there was something going on and she said, "Oh can I help?" and I said, "Oh I am trying to do this," and she helped and that was great. (Int P 20)

It was good having a nurse as a mentor. They were on the wards and we could just ask them questions. (Int P 28)

Mentor overlooked what I was doing, gave advice and pointed me in the right direction. (P 830)

Most importantly I felt with my knowledge I could guide them, help and in some cases protect them from more senior doctors. (M 110)

The mentors also agreed that the mentoring scheme was a good idea and a positive experience and should be continued in some format. Building junior doctors' confidence by giving tips and sharing expertise was one of many areas in which mentors believed they had helped PRHOs. They also provided a different professional perspective, thereby helping PRHOs with their decision-making processes, as well as giving an understanding of the contribution nursing makes to patient care. Mentors felt that they too had gained from the experience by becoming more aware of the training and teaching that PRHOs received, their role within the medical team and the stresses they encounter, hence making them more able to detect times of great pressure for the junior doctors. Table 18 in appendix E demonstrates how mentors believed that this project had helped them with their own personal development and increased their knowledge of interprofessional working and learning.

I didn't know other than through these (mentoring) *sessions just how much he was stressed, what was causing him to feel stressed. I mean I knew his workload was huge and I could have said to him "Do you want help with this?", but I didn't know which parts of his workload were causing him the most concern. I only learnt that through these* (mentoring) *sessions.* (Int M 21)

I very much enjoyed the experience and I gained so much from understanding how doctors think, work and have been trained. (M 110)

Very satisfying; has improved my awareness of the role of a junior doctor and increased my empathy. (M 112)

Mentors believed that interprofessional mentoring also benefited the working environment by improving the working relationship between doctors and nurses (81%), improving communication (79%) and interpersonal relationships (77%) between the two professional groups, as well as improving patient care (57%).

Summary and implications for practice

Mentoring different professional groups was found to be a positive experience by most participants. Reasons identified included the support received in the early days by the junior staff, improvement in communication and collaboration, and better understanding of roles and responsibilities. In addition, the benefit for the mentees was the security of knowing someone was there to help, and for the mentors, the satisfaction of being of support to someone else. Mentors believed they had benefited professionally from the experience and witnessed improvements in care delivery due to better communication.

The advantages expressed by both mentees and mentors again confirm that interprofessional initiatives are practical and of benefit to staff and patients alike. The implications for practice are in finding ways of introducing these initiatives so that they do not impose too much pressure on the staff or require

too many additional resources, which may make individuals and institutions reluctant and resistant to such schemes.

4.6 Perceived challenges of interprofessional mentoring

Although interprofessional mentoring was evaluated positively by most interviewees, there were some challenges and obstacles identified. The practical issues that made the mentoring process problematic are shown in Table 5. These practicalities centred on the accessibility of the mentors and mentees for the purpose of meeting and working together. Additional problems were mainly due to various organisational and professional requirements. The other major obstacles included personality and attitudes of individuals, developing interpersonal relationships and identifying the best person for the role of mentor (e.g. ward nurses versus nurse practitioners). Some of these problems were also true for the data collection of this study, e.g., finding a suitable time and venue for the interviews.

Issues	**Implications for mentoring (with supporting quotest)**
Shift work/patterns	• Nurses have three working shifts (early, late and nights) • Doctors mainly work Monday to Friday during the day, but shift patterns are being introduced for them in some areas • Hand-over for nurses reduces the number of staff on wards and time available for interaction with other professionals • A significant number of nurses work part-time or job share, making them less available to junior staff '*Because I manage my own workload as such I can perhaps structure my day differently from somebody who is part of a nursing team. The only thing is I am sort of there technically Monday to Friday, nine to five. Whereas you can have two people working completely opposite shifts and they might not meet for weeks.*' (Int M 21) *'And I also think that probably being part-time could cause problems, although I work every Monday and Tuesday; possibly if they were having problems you don't have such presence.'* (Int M 13)

Workload/practices	• Radical changes in the PRHOs' working hours mean heightened stress levels due to the same amount of work needing completion in fewer hours. Also, reduced time means less opportunity for interaction with other professional groups • Senior nurses are constantly taking on more advanced practices, thereby increasing their workload and their availability to junior staff • Junior doctors need to be in various places (clinics, teaching session) which make them less visible and available to mentors • Lack of time due to workload was mentioned by all the participants and was a major factor in preventing meetings between mentors and mentees • Senior nurses had limited time and felt overworked because they also had many nurses/student nurses to preceptor/mentor *'It's a very difficult problem because I think medical and nursing working patterns are so different. The other problem is that medical working patterns are changing radically at the moment because of the working hours, the training of doctors, there are radical changes there too.'* (Int CT 3) *'I think not having time to actually sit down and speak to the PRHO. I think that's a downfall of it really.'* (Int M 30) *'I think I was sceptical before with the workload, I just felt like something else to do, somebody else to look after. Who is looking after us?'* (Int M 31)

Clinical area: 1. Being on same ward 2. Patients on various wards 3. PRHO rotations	• All interviewees identified the need for mentor and mentee to be on same ward to help with personal and working relationships • Consultants no longer have one ward assigned to them but rather have patients across five, six or more wards. It is difficult for junior doctors to develop meaningful relationships with 20-30 nurses on each ward • PRHOs' rotations meant they moved on after two or three months which made it difficult to continue meeting with their mentor *'I think particularly being ward-based, I'll quite quickly get to know the nursing staff and so it will be much easier.'* (Int P 8) '*Yes make sure HOs* [house officers] *are working on the same ward as nurse.'* (P 951) *'...so it's actually the two people* [doctor and nurse] *being able to talk to each other and being physically in the same place at the same time...The ones who found it particularly useful are the ones where the nurses are on their ward and easily accessible, so ones where the nurse maybe is not around so much because they are on a different ward, then it is not being perceived as being so valuable.'* (Int CT 26) '*Within the medical profession but also within individual teams, because of the hours you're not doing on calls with other members of your team as you were previously* (you are not building relationships)*; you're doing less hours, more shift work patterns are coming in and therefore you don't get to work and know the team as well as you did five or six years ago.'* (Int MD 11) *'I think probably if they're on the same ward as you and you are working with them all the time you can be far more supportive but you can't if they're elsewhere, because I mean I can probably go weeks without seeing them* (the mentees) *unless I actually get to the phone and then if she* (the mentee) *is busy or on call it's not so easy.'* (Int M 32)

Table 5. Practical issues causing challenges to shared mentoring identified by the participants

According to the mentors, the responses from the mentees were varied depending on their needs and attitude. Contact with mentors varied from none to some during the initial period, to a small number who continued to use the mentor as a friend and for support, and developed a close working and personal relationship with them. In the latter scenario, the mentors suggested that the positive experience of mentoring was due to the personality and attitude of the individual PRHO. Two mentors expressed a negative view of interprofessional mentoring mainly because their PRHO did not have an interest in the project or in learning with, about or from other professional groups. This was also true in terms of the personality of the mentor and how they approached the role. Junior doctors made use of those nurses whom they felt were approachable and appeared interested in helping them, and they believed that mentors should be chosen from this group of individuals. It was acknowledged by all that there are sometimes personality clashes and that a mentor and mentee relationship would not be exempt from that.

> *I think it had a lot to do with her personality and who she is, that she is a good mentor... Some of it boils down to the personality definitely.* (Int P 8)

> *It* (mentoring and supporting) *has the potential for happening anyway and that depends on the personality of the particular PRHO and the particular nurse they are seeing.* (Int CT 26)

> *The obvious ones are sort of personality problems and choice of individuals on either side and matching them up, and having some mechanism for people to say no I don't want to be in touch with them.* (Int CT 3)

> *A positive experience. Project somewhat determined by PRHO's personality/interest in taking part wholeheartedly.* (M 716)

> *Some people are much better communicators than others, some consultants don't think it necessary to tell the nurses anything, some sisters think that patient care is totally down to them and doctors are just inconveniences that come on the ward twice a week or something. As much as anything, people getting on with everyone are much more inclined to tell them what's going on and to try and get involved. Whereas if they think they're just going to get shouted at, they might not bother and just write it in the notes and things can get missed, and I think people try their best but when you feel that somebody's not receptive that's when it falls apart.* (Int P 27)

One clinical tutor believed that the point of mentoring was to find the best individual and personality who could mentor a new member of staff in the stressful early days of their practice, rather than getting one professional group to mentor another. However, since one of the purposes of this scheme was helping junior staff become aware of the role of other professional groups, the need for some cross-professional mentoring to aid the process became apparent.

> *Again, the whole essence of this set-up was to find suitable individuals, just because you're a senior nurse you can't mentor a PRHO, you had to find appropriate personalities of people to do it...* (Int CT 3)

Nurse practitioners were identified as being the best group to mentor junior staff. It was felt that in their capacity and role they crossed the boundaries of both professional groups and could be a great asset in raising awareness and knowledge of the other professions. Whilst spending some time on the wards waiting for the participants to interview I was able to observe some of the working relationships amongst staff. It appeared that nurse practitioners worked well with both professional groups and both nurses and doctors called upon them for support with their work. A challenge to this in some Trusts was that nurse practitioners had become fully integrated into the medical team,

thereby losing their contact with the nursing staff. This was dependent on the nurse practitioner and on their training. In one Trust, nurse practitioners had distanced themselves from the nursing staff, which was evident from their approach and from the comments made by some of the nursing staff about them. However, for some mentors (who were nurse practitioners) mentoring seemed an appropriate role to take on because they already had to work closely with PRHOs and it gave them the opportunity to enhance the effectiveness of this relationship.

From the interviews, it was clear that it was the qualities the individuals possessed that made them good mentors, rather than their particular profession. The qualities identified by the participants included being friendly, approachable and available, always having time for the newly-qualified staff, and being knowledgeable, experienced and willing to help.

> *I think being a nurse practitioner helps because that is my job to cross both fields anyway; that is in my job description – it was very much easier. If I had done it from a purely nursing background as in some of my other jobs in the past I don't know how easy I would have found it. It might have been a little bit harder.* (Int M 21)

Summary and implications for practice

Mentoring was used to varying degrees by junior staff depending on their needs and on their own personal views and attitude towards the initiative. For PRHOs, mentoring was something new that they needed to understand and engage with. There were areas of difficulty within the study such as personal views and personality clashes, shift and work patterns, time and workload. Developing a personal relationship between the mentor and mentee was seen as essential for the experiences to be productive and meaningful but the factors mentioned above prevented this relationship developing as quickly or efficiently as it could.

Individuals play an important role in making an initiative a success or a failure. When introducing interprofessional mentoring, it is vital that those involved initially are supporters of collaboration between different professions.

4.7 Culture and socialisation of the profession

The interplay between the two professional groups was mentioned by many of the participants. The existence of a distinct culture within each group was evident from the beginning of the study and was acknowledged by most interviewees. This was observed at the beginning of the project during the introductory sessions with both mentors and mentees. Also, mentoring was generally associated with the culture of nursing practice rather than medicine.

> *They are very different cultures.* (Int M 10)

> *I think there are different cultures; I think they both believe they are in a different culture.* (Int M 21)

> *I suppose it is partly because mentoring is in the nursing culture already and not particularly in the medical culture, so I think that just might take a little bit more effort with the mentors to get it running, and in exactly the same way nurses have little idea what the medical structure is for support and help and where do you go if there is a problem.* (Int CT 26)

Within culture and socialisation is the concept of professionalism. Professionalism and what characterised the nursing and medical professions were seen as part of the variations in the functioning and culture of the two disciplines. It was interesting that participants repeatedly mentioned terms and words such as professionalism, professional identity and professional boundaries. Participants in this study had strong views about their profession and its contribution to healthcare, along with perceptions of the role of other professional groups. There were features of their own professional role that many participants were attached to (e.g. working in teams for medical staff and certain aspects of patient care for nurses), and there were roles that were attributed to the other professional groups, which were seen as setting the boundaries between the professions.

Besides professional roles and responsibilities, there were behavioural characteristics that were attributed to other professional groups, developed through the socialisation of students and newly-qualified staff into the profession and reinforced by senior role models. The characteristics associated with each profession have also led to the stereotyping of that professional group. This has impacted on the creation of the groups' cultures and created a power struggle between the groups. Figure 1 below demonstrates the links made by the participants about this theme.

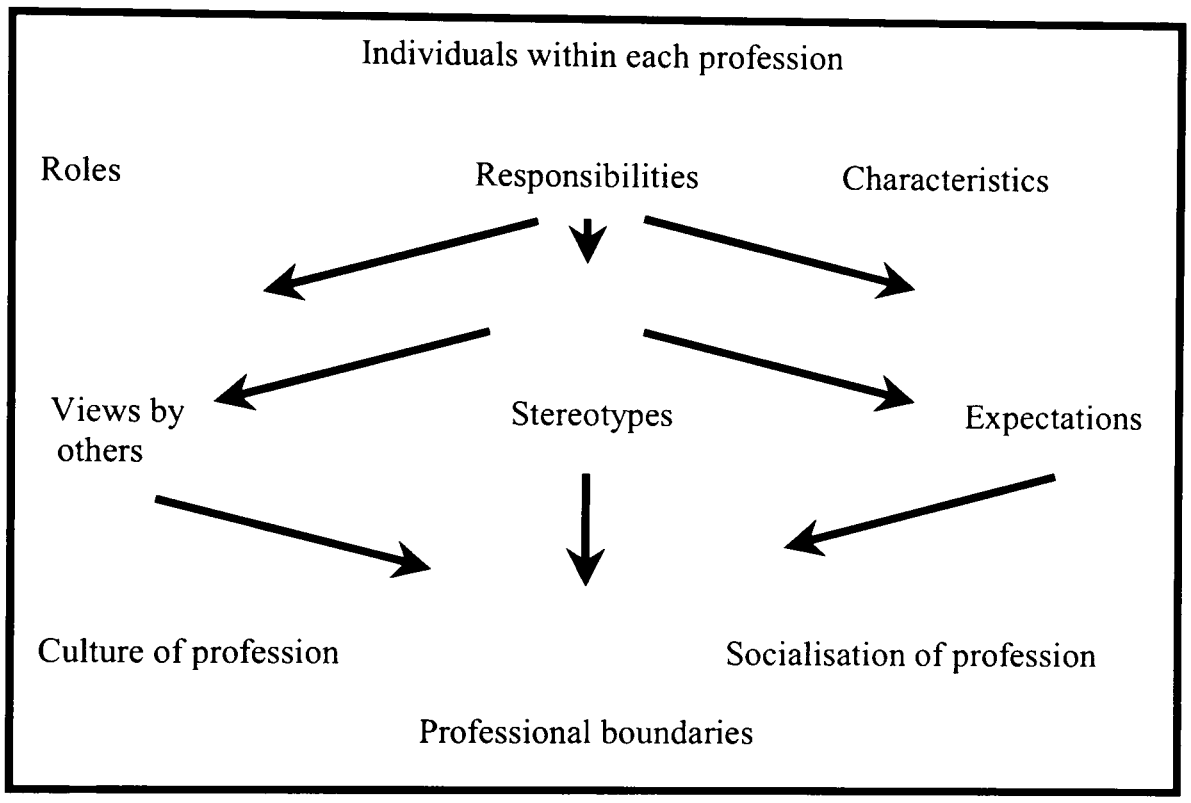


Figure 1. Words and attitudes associated with culture and socialisation of professions

The concept of professional roles was mentioned by many participants and the lack of understanding of the roles of other groups was seen as a barrier to a more collaborative approach to working within healthcare. Not being familiar with the roles of others caused individuals to have strong views about other professional groups. This led to stereotyping, based on inaccurate information or hearsay from more senior members of staff. This was evident when interviewees were explaining a particular characteristic about the other professional group, for example nurses commenting on the arrogance of doctors in general, even though they only attributed it to a few. Doctors also mentioned how nurses did not want to take responsibility for anything and so contacted them too frequently and would not take the initiative. These views

and perceptions caused members of each professional group to have certain expectations of each other.

> *As a doctor, it's difficult. I think we all know what the stereotypes are that nurses have of doctors and doctors have of nurses, and stereotypes are there for a reason because unfortunately they come about because a few people do believe them and you do see that. I think a lot of nurses do see doctors as being arrogant, aloof, sort of holier than though attitude and a lot of doctors perceive nurses to be intellectually inferior, unwilling to take on clinical responsibility. Those stereotypes exist and it must be said that there are doctors who are aloof, arrogant, just as there are probably nurses who don't want to take on responsibility. So those people exist but I don't think that necessarily means that all doctors or all nurses are like that, but yeah, those stereotypes exist.* (Int MD 11)

> *... and I think a lot of doctors do feel they are superior...* (Int M 13)

> *There are a lot of other problems which I think are to do with professional boundaries, attitudes of all the different groups involved and lack of knowledge of what each other's expectations are of one's own role and each other's expectations of each other's roles.* (Int CT 26)

Some participants gave the different roles a hierarchy of importance. This was also observable on some of the wards, where for example, only some nurses were involved in doctors' ward rounds or doctors refusing to change intravenous infusions. One consultant had very strong views about what doctors and nurses should do – clear distinction and degrees of importance were given to various jobs along with the level of knowledge and training required for each of the tasks.

> *Being a doctor isn't about emptying bedpans; it's making people better... that is not what they have taken a degree for.* (Int CT 7)

For participants, these issues highlighted the need to know about the roles and responsibilities of other healthcare professionals. One PRHO, for example, expressed his confusion about the different grades of nurses and what they were able to do. A few PRHOs alluded to the expectations of nurses about what they, as junior doctors, were able to do. Mentors also mentioned that not all nurses know what PRHOs can do when they first start. One approach identified by many participants for increasing understanding about roles and responsibilities was closer working conditions. This, they believed, would also bring about a change of opinion about others and would lead to respect for other groups and their contribution to healthcare.

> *...I'd figured out the training grades that nurses had and the way they trained and the differences, you sort of find out. I suppose I found out a little bit informally as I've gone on but I don't have much knowledge really and certainly the nurse I talked to didn't have much knowledge of what we did either so I'd say it's fairly separate tracks really.* (Int P 20)

> *The way you change your opinion of people is by working with them and getting to know them and I think the way that doctors will get to respect nurses is by working closely with the same group of nurses rather than going to lectures with nurses, and I think the way nurses will respect doctors is if they get to know doctors, understand their working patterns, get to work with them closely possibly.* (Int MD 11)

Some participants had strong views about maintaining professional boundaries as they believed each profession has its own distinct tasks and responsibilities, while others described it more as a teamwork approach, requiring different professional input with less emphasis on the intricate details of professional boundaries. Nurses and doctors both highlighted the expertise that they gained

through their training and education as well as through practice, experience and observation of senior colleagues. Doctors and nurses mentioned that by watching and observing more senior staff (of the same profession), they were able to develop their own clinical skills and knowledge.

These views, perceptions and stereotypes, developed over many years, have contributed significantly to the power struggle between the two professions. The roles, traits and characteristics given to each profession were associated with levels of power. For example, doctors were perceived as having a greater scientific knowledge base and as being more willing to take on responsibility; therefore they should make the decisions about patient treatment. Nurses were perceived as being more involved with caring for patients and liasing with professionals allied to medicine, which was viewed by some medical staff as being less important. Low self-esteem within each professional group was also evident in the way professionals described their role and their interaction with members of the other group. Examples include mentors lacking in confidence about mentoring a junior doctor and junior doctors suggesting that nurse mentors would not be able to help them educationally.

> *I think it was more that I felt the things I needed to know educationally were things that she wouldn't have known or that she wasn't expected to know.* (Int P 27)

> *Having been mentor for student nurses that was obviously what we talked about in the beginning: anxieties about would the doctors want to be mentored by me, a nurse, and I did feel at times although she is absolutely brilliant, I think she was possibly humouring me a bit.* (Int M 13)

There were several examples in this study where the mentors and mentees alluded to the level of knowledge and ability of the other professional group. One mentor mentioned how nurses were becoming too academic and losing the essence of their profession, which is about hands-on nursing and caring for patients. A PRHO expressed his perception that the specialist nurses were there

for the purpose of aiding doctors rather than for their own professional development and interest.

> *I mean, the people who are qualifying now are coming out with more qualifications than people used to come out with, and again I don't agree with that really. I think a good nurse just needs common sense and I don't think having seventy-five O-levels is going to make any difference to somebody who's got one O-level who's got all the common sense that you need and will make an excellent nurse. But that's just my own personal opinion and I think that could be one of the reasons why we won't get people in the profession, because they've set the qualification standard too high.* (Int M 10)

> *Well we've got specialist nurses all over the hospital doing different jobs for us* [medical staff]*; anticoagulation, diabetic nurses, vascular nurses... All sorts. Also down to phlebotomists who are kind of taking blood for us – I'd have to do that if they weren't around.* (Int P 16)

Summary and implications for practice

For professions that have functioned for many years as their own entities with separate training, it is understandable that a particular culture has developed, as acknowledged by all participants. There is a lack of understanding of roles and responsibilities due to minimal interaction between the professional groups, which has led to less collaborative working conditions and the development of perceptions and stereotypical views of other healthcare professionals. This in turn has created an environment that competes for power and acceptance as a profession. This power struggle affects any interprofessional initiative and, therefore, needs to be tackled if any progress is to be made in this area. The negative views and lack of respect for other professional groups can be eliminated through education and experience of collaboration.

4.8 Experiences and understanding of interprofessional working/education

There was confusion and lack of consensus about the meaning of interprofessional working among the participants and various examples were given of what constitutes this form of working. Some viewed it as team working among the various grades of one profession, whereas some saw the team as including any employee within the hospital, even the chaplain and chefs. It appeared that senior and management staff understood that there was a Government agenda in relation to interprofessional working, which was why so many initiatives were suddenly being introduced into the health system. Clearly there was no comprehension or agreement about the term interprofessional or its practicalities. Therefore, the participants were left to answer the question about what interprofessional working means according to their own understanding, which added to the variance in answers. It was a useful exercise in demonstrating the need for more clarity of the term.

> *Interprofessional working would be much more a partnership of equals each bringing their own skills, attitudes and knowledge for the benefit of the patient.* (Int CT 26)

> *Different sub-sets of the same medical team or different professions, if you like, for want of a better word, working in the same hospital environment towards the same goals but just taking different aspects of patient care as their responsibility.* (Int P 27)

> *I think it means different professional working together as a team really.* (Int M 13)

Some participants believed that interprofessional working was about a collaborative team approach. It was more than just referring patients to various professions or agencies. The terms 'collaboration' and 'team working' were deemed important. The interviewees focused mainly on the process-based

aspect of an interprofessional approach as outlined by Leathard (1993), which is about teamwork, collaboration and shared learning, with little reference to the agency-based category that incorporates interagency and cross-agency work. Although participants mentioned social workers, there was no reference to working across agencies, only professions.

> *It's* (interprofessional working) *a collaboration of different professions in caring for patients and working together...* (Int M 9)

Most participants saw interprofessional working as two or more healthcare professional groups working together in providing patients care. The main professional groups mentioned consistently by the interviewees were doctors, nurses and physiotherapists. Others used professionals allied to medicine (PAMs) to incorporate other healthcare workers besides nurses and doctors. Occasionally occupational therapists, dieticians and pharmacists were mentioned separately. Interestingly, social workers were only mentioned a couple of times as part of the interprofessional group, even though some PRHOs remarked on their frequent interactions with them. The chaplain was mentioned by a consultant and two nurse mentors, while other nurse mentors mentioned the cleaning, catering and clerical staff.

> *I guess you are pretty much a coordinator of what goes on with the patients and what needs to be done for them, and just work in a team, really; obviously with the physio team and dieticians and what not.* (Int P 16)

> *Interprofessional means to me, working with all disciplines, nursing, doctors, physios, OTs* [occupational therapists], *the full interdisciplinary teamwork to make it more effective, obviously to benefit the patients and supporting each other, gaining knowledge from each other.* (Int M 12)

Due to the differences in opinion about what constitutes interprofessional working and the different applications of it in practice, it was difficult to

measure the participants' level of experience of this way of working. Two project leads had experience of working and learning with other professional groups by virtue of their role within the Trust (for example, as the resuscitation officer). Clinical tutors, by way of their clinical area, e.g. intensive care, had more experience of working in multidisciplinary teams. Some PRHOs described limited experience of interprofessional learning during medical school, including a single day of shadowing a student nurse on the wards, multidisciplinary teaching (ranging from one session to a few sessions or day-long workshops) with student nurses or sometimes other groups, attendance at multidisciplinary review meetings for patients and advanced life support courses. Mentors had similar experiences of interprofessional working and learning and gave similar examples as the PRHOs. These included attending courses and workshops on diabetes and advanced life support with other professional groups, multidisciplinary patient review meetings, assisting junior doctors, and some clinical work such as multidisciplinary discharge planning. Many of the participants also commented on the need for more interaction between the various health and social care students to prepare them for team working in practice and to provide them with skills to work collaboratively.

> *Well, I know at university we were supposed to have several sessions working with trainee nurses and physios and OTs, just sort of joint sessions doing the same sort of thing, to help with that* (collaborative working). *I can't really remember many happening but I think that's changing.* (Int P 14)

From the responses in this study, it appears that certain clinical areas are particularly suited to interprofessional working. Participants identified various practice settings that could easily adopt an interprofessional approach to practice, some of whom had personal experience of collaborative working among the various healthcare professionals. The most frequently mentioned areas were elderly care, oncology, psychiatry, mental health, intensive care and theatres (anaesthetics and pain control). In these areas there were teams of professionals working closely together, which participants classified as interprofessional working.

> *Care of the elderly has probably got the most formal way of interprofessional working relationships, and by that I mean they actually have dedicated meetings, dedicated ward rounds where nurses, occupational therapists, physiotherapists and social workers will turn up and every single patient is discussed at every level and that happens on a regular basis, and as far as I'm aware that doesn't happen in medicine as a whole.* (Int MD 11)

The interview participants identified both advantages and barriers to interprofessional working. It was agreed that interprofessional working would improve communication and so enhance patient care. This was also demonstrated in the questionnaire whereby senior nurses acting as mentors believed that the interprofessional mentoring project, on its own, had improved working relationships (81%), communication (79%) and patient care (57%).

> *This is a great opportunity to improve communication/working relationships.* (M 405)

> *It* [interprofessional mentoring] *does improve communication and working relationships...It* [interprofessional mentoring] *has been a very worthwhile experience. I feel very strongly with this initiative and would encourage its continuation in the future. I hope that it has made a difference and helped improve communication and relationships between the two disciplines.* (P 417)

> *I think the more the professions work together, hopefully the more they'll come to understand each other and communication is bound to be improved as a result of that as would all sorts of other aspects of healthcare work.* (Int CT 3)

One hindrance that was mentioned by a number of participants was the possible unwillingness of more experienced staff to change their practice to work with other professionals. For example, one senior nurse who was

mentoring a PRHO did not believe it was his role to help and support another professional group, since he had enough nurses to look after. He also did not feel that the junior medical staff had enough respect for nurses. Therefore, he clearly was not interested in changing current practice. Interestingly, he had trained to be a nurse in the army, where there is a clear hierarchical structure in place with distinct power distributions. There were similar attitudes of unwillingness among some of the medical team, who had strong views about their team's structure and how it functioned. For example, they used the term 'the firm', referring to the consultant as the head of the firm with the ultimate power, followed by the registrar, the senior house officer and finally the junior doctor, who had the greatest interaction with the nurses and other professional groups.

> *I suppose some older members again, people who've been in the profession for years who are obviously very experienced and know what they are doing, might find it more difficult to change and understand what other people are doing.* (Int P 14)

> *The first aspect is if people take very archaic views on what their job description is, i.e. the old doctor role, doctor knows best, doctor will make a decision and the nurse will abide by it, and vice versa, if nurses take that role as well, where they don't want to get involved in either responsibility or management and they just take a very subservient role, then that really isn't a sort of symbiotic relationship.* (Int MD 11)

Therefore, reluctance to change, unwillingness to give up old patterns of work and wanting to maintain power, all influence the advancement of interprofessional working. However, changes are happening according to many participants and one clinical tutor gave the example of audit meetings where nurses and doctors work together. He shared his reflection of such meetings, '*Where a nurse was presenting to a room full of consultants and a fellow consultant turned to him saying that things had moved on if they were being taught by a nurse'.*

It became obvious that there is a need for commitment by individuals and a positive attitude towards interprofessional working if practice is to become more collaborative. For example, a mentor who wanted to ensure that the junior nurse mentee could join the PRHO for the shared learning sessions found opposition from the charge nurse who did not see the merit of joint learning sessions. Another issue was the sharing of negative views about the project by senior staff. This impacted on some PRHOs who subsequently did not make use of their mentor for fear of senior staff disapproval. Conversely, a few interviewees expressed how individuals who were enthusiastic about interprofessional working could advance the process at ward and Trust level. Therefore, individuals can be a hindrance to interprofessional working if they strongly oppose the idea whilst others who are positive about collaborative working can be a catalyst. Hence, the focus needs to be on those who are keen and want to drive interprofessional working forward.

> *I think the best way of always taking a new project forward is to find enthusiasts and to build on sort of nuggets of enthusiasm. To find areas where what you want is already happening automatically and try and build on that, so I suppose the key thing is to identify senior enthusiasts in both specialities or in both professions.* (Int CT 3)

Summary and implications for practice

Ambiguity about the meaning of the word 'interprofessional' meant that the participants' views, understanding and experiences were quite different. Many had some experience of either interprofessional working or learning. Certain areas were more likely to involve interprofessional working due to the nature of care delivery and individuals were seen to play an important role in either encouraging or discouraging an interprofessional working environment and practice.

In implementing such initiatives, it may be necessary to identify enthusiastic individuals to lead them and start in areas where some team or collaborative work already exists. It would, therefore, be easier to build on these foundations and increase interprofessional working in such areas. Once a

scheme is firmly established and positively evaluated, it can be slowly transferred to other areas using the aspects of the scheme that are more beneficial and successful.

4.9 Need for a collaborative team approach

The aim of interprofessional working was viewed by all participants as a means of working together with other professional groups. Every participant acknowledged the need for collaboration between the groups, namely understanding and respect among the professionals involved, sharing information and working effectively together to manage the care of patients. Participants viewed the level of information sharing and collaboration differently. One senior doctor believed that collaboration happened all the time in practice. At its simplest level he described the admittance of a patient with infection requiring antibiotics: the patient is seen by a doctor who decides on the diagnosis and treatment and communicates this information to the nurse who administers the medication and updates the doctor about the progress of the patient. However, according to the general consensus from the other interviews, this simple approach is not an interprofessional one but rather a linear chain of events whereby each person carries out their own activity and forms a link in the chain. At a more complicated level, this senior doctor described specific meetings with members of many professional groups for the purpose of discussing patients at every stage of care delivery. It was acknowledged that this does not happen regularly due to the resources required. However, this approach best suits specialities such as care of the elderly and even necessitates it due to the complexity of the patients' needs.

Communication was seen as an integral and vital part of collaborative working. In this study, it was apparent that a lack of communication between the professionals was a major obstacle to successful collaborative work. Communication was identified by all participants as an area that needed to be improved dramatically to enhance the delivery of care.

> *Well, improved working relationships, but again that's born out of communication really. I think communication's the biggest thing. So often when things go wrong it's just because somebody's misunderstood or was misrepresented or there's been some confusion somewhere, so I think that's really key to most aspects of working together as professionals within the health service.* (Int PL 2)

> *I think communication is the big thing, good communication between each other.* (Int P 8)

Communication was divided into various categories. Some believed that written comments in patients' case notes were a form of communication that was sufficient for certain care pathways and clients. An example given was the admittance of a patient with an infection requiring simple antibiotic therapy. This case would require little communication except instructions and reports in the patient's notes, the prescribing of antibiotics by the medical team and their administration by the nursing staff.

However, both the medical and nursing staff interviewed explained that notes were maintained separately and that access to notes or inclusion of information was not always possible. For example, nurses do not write in the section used by medical staff and other allied health professions. Nurses' notes were kept at the end of the bed for each patient until discharge and not with the main notes. This meant that information about patients was sometimes not conveyed and so was missed. Participants gave examples of how discharges were delayed sometimes by days because of lack of communication and collaboration between the medical and nursing staff and between social services and the hospital in delivering the services required at home. This can be the result of a doctor requesting discharge in the notes but not verbally communicating this to the nursing staff, who do not routinely read patients' notes.

The next level of communication was the exchange of information about the patient by the different members of staff. This could be in many formats, through ward rounds or conversations between the doctor and nurse

responsible for the patient. The case conferences mentioned by a number of participants were viewed as the *'ultimate level of communication'* and involved many professional groups and agencies, including social services and, occasionally, carers. However, this happens less frequently and mainly for clients with multiple needs due to the time and costs involved in getting the various professionals together. The perceived improvement in communication within this study was between nurses and doctors rather than other professionals.

Mentors also expressed a 21% reduction in duplication of work and a 79% improvement in communication as a result of interprofessional mentoring, due to the creation of opportunities for communication between nurses and doctors during mentoring meetings and a better understanding of roles and responsibilities. Participants also believed that improved communication would enhance working conditions and 81% of mentors believed that working relationships between doctors and nurses had improved. Communication was also seen as an interpersonal skill vital for interprofessional working and improving working relationships among various staff.

> *There are selected bits where it works well, where you have some stability, like say the stroke unit or the rehabilitation ward, where there is stability of personnel and usually only one medical and nursing team involved and then you can build up your interpersonal relationships, which is what I would say is the key to interprofessional working.* (Int CT 6)

> *...need to have enough interpersonal skills to make them realise you're there as a supporter, not as somebody to get at them.* (Int PL 4)

It was interesting that participants identified lack of time as the cause of poor communication among healthcare staff, which sometimes led to barriers and disagreements and even instances of hostility and antagonism. Some more senior participants understood the causes of friction and overlooked such incidents, but some made them into professional issues claiming that all staff of

that grade and profession had the same characteristics. This adds to the stereotyping problem mentioned before, which causes further barriers to collaborative working. Another observable incident was during an interview with a PRHO, when he mentioned that he had respect for nurses and was aware of their stresses, and that sometimes pressures made individuals act inappropriately. He emphasised the importance of being patient and not reacting to situations. Interestingly, during the interview he was bleeped by a nurse and his tone and approach was completely the opposite of what he had just described. In my opinion he was not even aware of his own approach, which could be viewed by the nurse as arrogant or even rude. Therefore, self-awareness is vital otherwise individuals may act and react in a way that is confrontational without realising it.

Most participants agreed that placing patients at the centre of interprofessional care would be more advantageous to collaborative working. They believed that having the patient as the common goal would ensure that the focus would move away from professional issues and would ensure more willingness to work together.

> *I think the important thing is, there are a lot of cases, patients will see lots of different professionals but I wouldn't say there's any actual interprofessional working and I tend to see the important thing is some form of communication between the professions and some sort of shared aim or goal...But otherwise we are happy to blend our roles according to the patient's perceived need and I think that's where you see something working well when roles are reversed, but that doesn't happen very often.* (Int CT6)

> *I guess the distinction would be from the old-fashioned way of professions working together, of which the extreme model would be the consultant telling everybody what to do which is one form of team, whereas interprofessional working would be much more a partnership of equals each bringing their own skills, attitude and knowledge for the benefit of the patient.* (Int CT 26)

Although most participants mentioned the patient as being the common goal, in reality it appeared that each profession was more concerned with implications for their own practice.

Summary and implications for practice

Collaboration was seen as the main focus of interprofessional working. Communication, interpersonal relationships and common goals were identified as the three main components of collaborative working, with the first two being rated by mentors as having improved as a result of interprofessional mentoring in this study. Therefore, it appears from this study that opportunities provided for more dialogue between professional groups can lead to improvements in working relationships.

4.10 In conclusion

This chapter presented what the participants shared about their experiences of interprofessional mentoring and about their perception of the benefits of such an approach for supporting new staff. All participants were in favour of interprofessional education, which they believed would aid collaborative working and improve the practice environment. It was acknowledged that nurses and doctors have different priorities and learning needs.

Support in the clinical area and having someone to talk to about fears, worries and practical problems were viewed as most important by newly-qualified doctors who all expressed similar anxieties. It was evident from the interviews that support for junior staff comes from a variety of sources and is dependent on the experience and personality of the individual providing the support.

Mentoring different professional groups was found to be a positive experience by most participants. Mentoring was used to varying degrees by junior staff depending on their needs and on their own personal views and attitude towards the initiative. Collaboration was seen as the main focus of interprofessional working.

The major themes that emerged from the findings will be discussed in light of the literature in the next chapter.

Chapter 5

Discussion - Understanding the Journey

The main focus for my study was to explore the perceptions of junior doctors and senior nurses who respectively became the mentees and mentors in this study about interprofessional mentoring. Through interviews and questionnaires both before the study and after six months of mentoring experience, I was able to identify a number of themes. The themes that emerged focussed on being newly qualified and how an interprofessional approach to mentoring was useful in supporting and helping PRHOs with their personal and professional development. Through the analysis of the findings, it became clear that the development of professionals was very much embedded in both the culture of health care and the culture of the professional group itself. Healthcare workers go through different stages of growth in their journey towards becoming a practitioner and a professional. This is viewed as the socialisation of the practitioner which involves learning about and adapting the culture of their profession. Initially the journey had a strong focus on the individual (self) and their stresses, including aspects such as learning needs and their ability to cope, adapt and gain knowledge and experience. Once the individual was able to deal with their personal issues, they moved to the next stage of the journey, which consisted of relationships, collaboration and communication with others, including both members of their own profession and other professional groups.

From the data collected, it became apparent that the initial few months of practice were the most stressful, anxiety provoking and challenging periods for junior staff who required extensive support and learning opportunities. The findings of this study indicate that interprofessional mentoring aided the process of learning and provided support for new staff. In addition it influenced not only the mentors and mentees personally, but also the working environment and the relationship between professionals in practice.

This study only explored and discovered the first two stages of growth for a professional, but there are other stages as they progress through their careers and become more experienced in their speciality. Benner (1984) explains this

in her book *From Novice to Expert* where she shows how becoming an expert happens further on in the journey of a healthcare professional. The first stage that emerged from my study was about 'becoming' in relation to participants' own experiences, feelings, attitudes and needs. The second stage involved their development in relation to others around them, i.e. interaction with members of their own profession and other professional groups. These two stages corresponded with Benner's novice (limited experience of the situation they are expected to perform) and advanced beginner (can demonstrate marginally acceptable performance) stages in becoming an expert. By the end of their first year, the PRHOs in my study had moved on to the third stage of competency which is where, according to Benner, they see '*their actions in terms of long-range goals and hopes or plans of which they are consciously aware*' (p26).

Learning is the central feature of this continuum of growth. Wenger (1998) states that learning is most significant when it offers a way of being, an identity, rather than simply knowing about something. Learning should be considered from two perspectives in relation to medical education:

> *The first perspective is the* ***cognitive*** *perspective, which examines the processes occurring in the learner's thinking and memory. The second is the* ***social and environmental*** *perspectives, which considers learning as it is affected by the environment and the learner's interaction in that environment.* (Mann 2002, p70)

This is consistent with my study, where the journey of becoming a practitioner is seen in relation to the individual and their own thinking and actions, and in relation to others and the practitioner's interaction with them and their surroundings.

The findings established that the journey of becoming a practitioner was influenced by many issues, which merged into important themes and were grouped under the headings of personal, professional and organisational factors affecting growth and development (see Diagram 1).

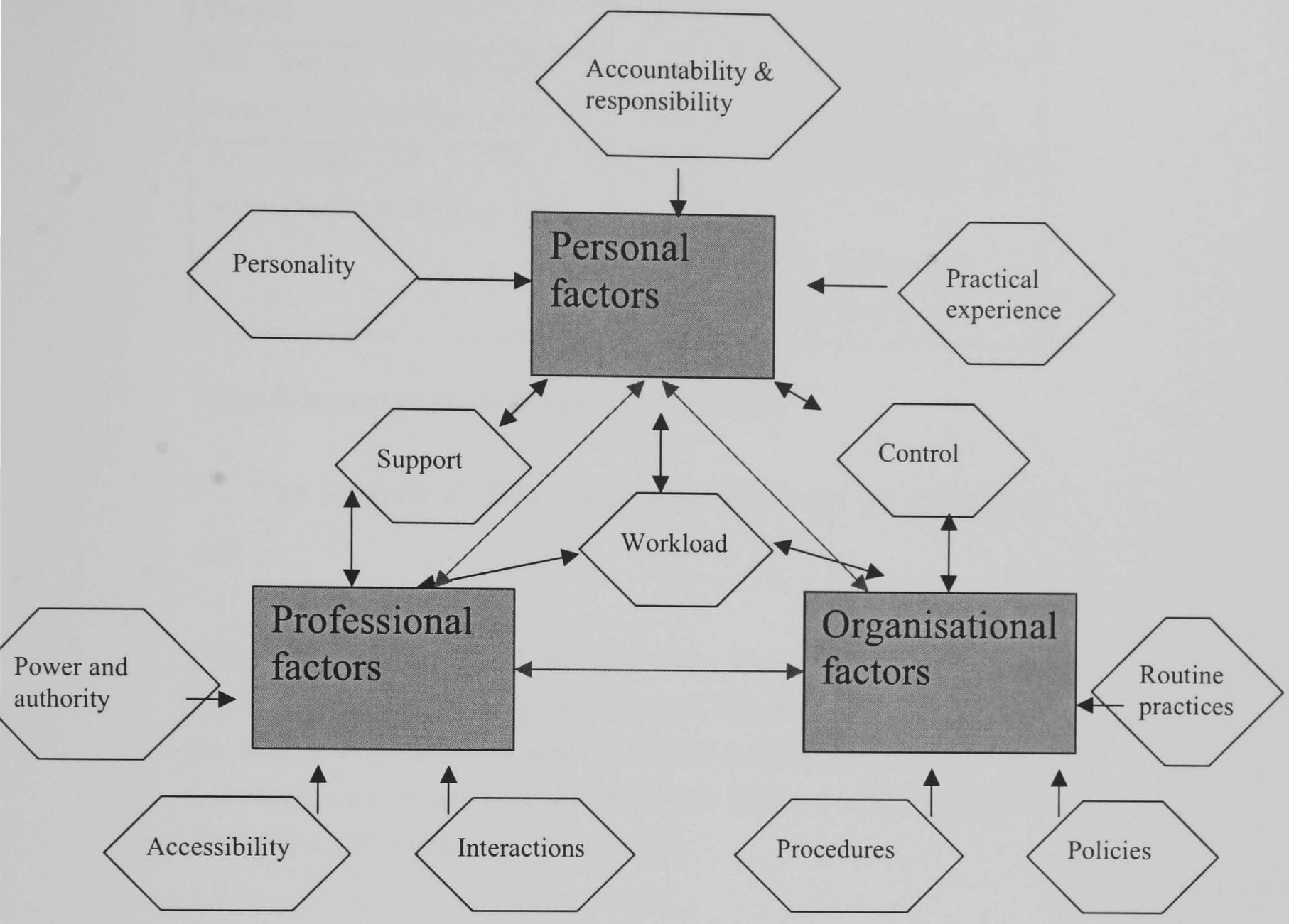


Diagram 1. Factors and related issues about becoming a practitioner

This chapter will explore the relationship between interprofessional mentoring and the journey of becoming a practitioner. The themes that emerged from the data (as demonstrated in the findings chapter) were further condensed into two main themes (see Table 6). The following pages will examine these two themes as well as exploring the contribution of interprofessional mentoring on collaborative working.

Themes	Sub-themes
The journey of becoming a professional in relation to self	Stress and anxiety of practice Learning to become a professional
The journey of becoming a professional in relation to others	Socialisation into profession and organisation Collaboration to aid practice and assist in becoming a professional

Table 6. Main themes and sub-themes identified from the findings

5.1 The journey of becoming a professional in relation to self

This section will be divided into three parts. The first will examine how participants perceived and experienced stress, followed by an exploration of the learning experiences and needs of PRHOs in the process of becoming a practitioner. The final part will demonstrate the influence of interprofessional mentoring on the learning process for PRHOs.

5.1.1 Stress and anxiety of practice

In answer to the questions on how they felt about starting as new doctors and their feelings and experiences of the first six months of practice, the words '*stress*', '*anxiety*' and '*worries*' were repeatedly mentioned by all PRHOs. Factors attributed to these feelings were: *'being new to the job', 'not knowing what to do', 'having responsibility and accountability for practice', 'lack of practical experience' and 'not having adequate support'*. Although the focus of the study was to examine the influence of interprofessional mentoring on new staff and their practice, the contribution that mentoring made to reducing stress for PRHOs made the theme 'stress and anxiety in practice' an important one. Although the remit of the study did not allow for an in-depth study of PRHOs' experiences of stress, the results did highlight important issues that are worth examining briefly at this stage.

Stress and anxiety of junior staff in the early days of their practice was a major factor expressed by all participants in this study. This, however, is not a new finding. The first few months of professional life and the transition from student to practitioner appear to be critical and are periods of crisis (Kjeldstadli et al. 2006), with major adjustment in terms of greater responsibility and socialisation into the profession and practice. Healthcare workers are believed to be particularly susceptible to stress because of the nature of their work and of having to be responsible for the health of others (BMA 1992). Although hospital settings are not new environments for junior staff, their new role and getting a post on a new ward or in a new hospital are unfamiliar. They have moved away from the familiarity and confidence they had in the university setting in which they spent a number of years. It is, therefore, natural to have worries and anxieties when starting any new activity or going into a new environment.

Participants expressed many reasons for the stress and anxiety they experienced, which stemmed from both internal and external influences. Internal causes were the junior doctors' lack of practical experience, their apprehensions and their fears of being '*on call*' or '*not knowing what to do*'. The external factors were the burden of responsibility and accountability, relationships with others, expectations of others and the impact of the environment e.g. workload and organisational functioning. A study by Paice et al. (2002) reported similar stressors, such as responsibilities, interpersonal relationships and workload, with the need for support for junior doctors. The main focus of the study was the identification of stressors using questionnaires sent to 2,456 house officers. Five broad categories – responsibility, interpersonal (relationships), death and disease, overwork and self – were identified by the team of analysers. There were many corresponding factors between their study and the findings from my study which are shown in Table 7. Even though the two studies used different methods (mine with a strong qualitative focus and theirs being a quantitative study), they share some similar findings.

Categories from Paice et al. (2002) study in hierarchical order	**Findings from my study**
Responsibility: • Competence • Experience • Most incidents in first few days • Night shifts • Inability to access senior staff • Lack of support	• Responsibility and accountability • Need to become competent • Lacking in practical experience • First few days the most stressful • Shift patterns difficult • Lack of support from senior team • Not always having SHOs or Registrars on team for support
Interpersonal: • Relationships in the work environment • Conflict • Communication problems	• Relationships with some senior doctors, but mainly with nurses and patients • Conflicts between different individuals or professional groups • Lack of communication and information sharing
Workload: • Intensity of work • Mundane or inappropriate duties	• Workload/shift patterns • More work in less hours • Being asked to do many routine and uninteresting tasks • Doing tasks others do not want to do
Death and Disease: • Death of young patients • Family members	• Dealing with patients • Dealing with relatives
Self: • Self-esteem • Career • Personal health	• Lacking in confidence • Worrying about registration and finding next job • Not getting enough rest and being tired

Table 7. Comparison of findings between my study and the study by Paice et al. (2002)

There are criticisms of the study by Paice et al. in terms of the timing of the study and the depth of the findings. Their study was conducted at the end of the first year of practice when perception of practice would be different to the first few months, and participants would possibly not remember all the critical incidences in the early weeks. It would have been more informative for the study to have been carried out at the end of the first few months of practice and repeated at the end of the PRHOs' first year. Also, although the questionnaire used an open question approach to identify the stressors experienced by PRHOs, there was a lack of more in-depth understanding of how these stressors impacted on the working patterns of PRHOs, which could have been obtained by follow-up interviews with a percentage of the participants. The use of naturalistic methods of data collection to provide personal descriptions of more complex interactional conceptualisations of stress is becoming more widespread and is of greater benefit (Hardy and Thomas 1998). This is particularly important since most studies into stress among junior doctors use questionnaires, such as, Peterlini et al. 2002, Jones et al. 2001 and Revicki et al. 1997. In my study, PRHOs were able to elaborate on why certain incidences or aspects of their job caused stress and how senior staff or their mentor could provide support. For example, one PRHO mentioned how the mentor was able to provide support when it was lacking from the senior members of the medical team.

My study relates more closely with Carson and Kuipers' (1998) model, which proposes that stress is a process with three levels: external, moderators and outcomes. They developed their model after examination, review and critical appraisal of work in the area of stress management and intervention, and based it on the model of stress process devised by Fagin et al. (1996) from the findings of three research studies on stress, coping and burnout. The first level consists of 'external stressors', which include occupation-specific stressors, everyday hassles and stress associated with major life events. These relate to some of the external factors in my study, which correspond with aspects of Carson and Kuipers' (1998) external stressors (Table 8):

From my study	Occupa-tion specific	Every-day hassles	Major life events
Major change in status (i.e. from student to practitioner)	●		●
Responsibility and accountability of being a practitioner (involves socialisation)	●		
Learning the day-to-day practice of the new job (involves socialisation and learning)	●	●	
Pressures of having to work with others (involves collaboration)	●		
Highly stressful nature of caring for others*	●		

Table 8: Correlation between external factors in my study and those in Carson and Kuipers' (1998) model

* Sandi Mann (2004) called this people work which requires and demands a degree of emotional engagement thereby causing stress if not managed

The environment and nature of work were highlighted by some participants as being major stressors. These included not knowing what was expected of junior staff, the extra workload and pressures placed on PRHOs, the amount of work, and in some instances, being caught in conflicts between two senior professionals. Payne's (1999) review of the literature on stress looked at the environment and highlighted the well-known work by Kahn et al. (1964) on role conflict, role ambiguity and role overload, which are all associated with higher levels of psychological stress in relation to an individual's occupation. Payne (1999) suggests that those who are in jobs with high demands and heavy responsibilities will feel less stress if they have more control over their work and more participation in decisions that particularly affect them. This confirms my study where participants mentioned how, on many occasions, they had little control over their work and, at times, experienced conflicts both in relation to their actual work and between staff. According to the participants, junior staff are in demanding jobs that do not allow them to have much control. They felt that others (consultants and registrars) made the decisions about patients' care and so dictated what the PRHOs had to do. Senior staff found they began to

understand their role better as they went through their training and felt more in control of their work.

At the second level of the stress process, discussed by Carson and Kuiper (1998), is the 'moderator', which involves personal coping mechanisms such as high self-esteem, good coping skills, hardiness, personal control, emotional stability and a good social support network. These can mediate or buffer the effects of stress. This level relates to the internal factors that contributed to stress in my study. Although all the PRHOs commented on the anxieties they had about starting as junior doctors, there was an observable correlation between those who had more confidence and those who were able to cope. For example, a few mentioned how they would turn to friends for support rather than to senior doctors or nurses and, because they knew it was going to be a stressful few months, some had mentally prepared themselves for it. This shows how they had developed strong self-buffers for any stress they might encounter. There were, however, others who appeared to find the whole experience of being new daunting, unsettling and demanding. They showed signs of stress unlike their colleagues (mentioned above) who had developed their own coping mechanisms and appeared more calm and untroubled.

Individual differences have been suggested to have a great impact on someone's ability to cope with stressful situations. Personality and self-belief are seen as major contributors in reacting to stress. Two well-known concepts in this area are Type A and Type B behaviours (Friedman and Rosenman 1974) and locus of control (Rotter 1966). Although these studies are now old, they are still of value. Through observations, cardiologists Friedman and Rosenman concluded that Type A personalities were more prone to suffer from coronary heart disease. They described them as individuals who strive to achieve, strive to meet deadlines and are hostile to those who may interfere with their achievement, with Type B personalities being the opposite. They suggest that Type A individuals seek out demanding situations and deal with them, but in the long term will suffer more stress.

I observed that those who demonstrated Type A behaviours were more confident and able to deal with the stress they encountered, whereas Type B individuals when placed in stressful situations needed much more support to be able to cope. In the six-month period of this study, it was obvious which

PRHOs experienced more difficulties with stress (as demonstrated by some considering leaving or actually leaving the profession). It would be interesting to follow all the PRHOs over a number of years to see if they all manage to develop sufficient coping mechanisms over time.

The theory of 'locus of control' is also believed to be a factor in perceiving and coping with job stresses. Spector (1999) describes locus of control as the individual's belief about being in control of outcomes in their life. He writes that:

> *Individuals who are at the end of the continuum (internals) believe they are in control while their counterparts at the other end (externals) believe that luck or powerful others control outcomes in life.* (p38)

The concept of internal–external locus of control, with its origins in the work of Rotter's (1966) social learning theory, has been used to predict a variety of health behaviours (Galvin 1997). This construct can also be used in relation to any behaviour by an individual that affects their actions and their interactions with others. Accordingly, it could be argued that those junior doctors who are externals would report higher levels of job stress and anxiety at work than internals who would be able to find their own mechanism to deal with job stressors. Rotter (1966) contended that individuals who perceive the outcome of life events to be contingent on their own actions and behaviours are better adjusted emotionally than those who view outcomes as dependent on external factors. Consequently, those who function with an internal locus of control adapt better than those with an external locus of control (Hardy and Thomas 1998). It is worth noting that in my study the PRHOs who expressed greater anxiety were those who were particularly concerned about their assessment that would ultimately affect their registration and which was dependent on someone else (the consultant).

In relation to this study, PRHOs demonstrating internal control were able to interact easily with other healthcare professionals. The junior doctors who were more confident and appeared to be outgoing felt they could approach anyone on the wards for help and did not feel they needed to have a nurse mentor. They were able to gather their own social support around them and deal with their workload or job stressors, thereby not expressing the severity of the job

pressures they experienced. The PRHOs who expressed a great deal of stress and mentioned that they found the nurse mentor very helpful were those who constantly mentioned not having any support from the senior medical staff or from nursing staff on the wards. This demonstrated the need to have a mentoring system in place for those who depend on others for support and direction in their work and who may lack the ability or confidence to approach others for help. This study did not measure the locus of control; this is an area that could be the focus of future studies on the benefits of interprofessional mentoring.

Stress outcomes are the third level of stress in Carson and Kuipers' (1998) model. Positive outcomes result in mental and physical health while negative outcomes can cause ill health and burnout. They believe that having moderators allows for a positive outcome. Their model acknowledges how external influences cause stress but places the whole emphasis on the individual's ability to deal with that stress. Although findings from my study showed some similarity with Carson and Kuipers' model, where certain factors influence the stress level of individuals and where their ability to cope with that stress will determine a health outcome, there was an area of disagreement between my study and their model. The emphasis placed on the individual's own ability to deal with the stressors was the main factor in their model. However, participants in my study expressed how they would be able to cope better if they had support, especially from senior staff as well as the organisation, through the implementation of systems to improve their daily working environment. Examples given were having someone who could answer their questions, watch over their work, help them with patients and deal with other staff. They not only saw external factors affecting their stress levels but sometimes saw the same factors helping them cope with their stress. For example, participants expressed how consultants (40%) and junior nurses (38%) increased their stress levels, but also identified consultants and senior nurses as those who helped them deal with their stress. Responsibility and accountability (85%), workload (83%), long hours/shift work (72%), lack of support (60%) and uncertainty of what they were expected to do were viewed as major factors affecting stress levels. However, participants believed that coping was about their ability to handle and manage work situations, but that

this was aided by the support and encouragement they received from others i.e. senior staff and the organisation for which they work.

Taking responsibility and being accountable for their practice was the highest rated stress factor (85%) by participants. Throughout the interviews many of the stressors mentioned by PRHOs and mentors were closely linked with or were part of the process of taking responsibility for professional actions and decisions. Almost all PRHOs commented on the fear of not knowing what to do, particularly during emergencies, drug calculation and administration and while carrying out certain clinical procedures, because throughout their training these tasks had been the responsibility of the qualified staff they worked with. Paice et al. (2002) concluded that, although learning to take responsibility is a process in the making of a doctor, it is important that junior doctors are supervised and not left alone to deal with emergencies during the first few weeks in post. The whole issue of taking responsibility is also linked to the junior doctors' level of confidence, and amount of knowledge and experience. The lack of practical experience and of linking theory to practice caused their anxieties about taking responsibility. According to Williams et al. (1997), rising levels of confidence and competence are the likely cause of the steady reduction in depression and stress in doctors over the first few years after graduation. Therefore, as PRHOs gain more experience, their confidence increases, they are able to accept their responsibilities more readily and are less stressed at work. This was demonstrated in my study as the junior doctors' behaviour changed between the two interviews (pre- and post-mentoring), showing more confidence and less stress.

Stress has implications not only for the individual but also for the profession. Retention of staff is becoming a major issue (Harvey et al. 1998, DOH 1997) and one that needs to be further investigated. From among the participants in the interviews, there were two PRHOs who left within the first six months of their jobs. According to the clinical tutors, their resignations were due to job pressures. Two further PRHOs expressed their wish to leave the profession after the first year once they had gained their registration. They, too, felt the pressures of medicine, the lack of support for managing workload and poor professional development as being the factors that contributed to their decision to leave the profession. It is imperative to know the reasons why new

graduates leave the profession if the current shortages in health care are to be tackled. Retention of doctors is a major issue considering that the cost of one doctor's training is between £156,000 and £188,000 if a degree is intercalated (Grainger 1997). There has also been a fall in applications for university places of 2.7% between 1985 and 1991 and of 19.6% between 1996 and 2001. Lowry (1993) suggests several reasons for this, such as heightened awareness of working conditions and hours, comparison of pay with other professions and a change in public attitude towards doctors. A study by Harvey et al. (1998), using postal questionnaires to doctors, found that the most common reason for leaving was poor working conditions (long hours and their effects), disillusionment with the National Health Service (NHS), followed by career and training opportunities, as these, in their opinion, were lacking within the NHS. This correlates with my study which demonstrates that stress factors for PRHOs still remain and that adequate solutions have not yet been implemented.

Most studies investigating stress among healthcare staff, particularly junior doctors, have been quantitative in nature, using mainly postal questionnaires and well-known scales such as the General Health Questionnaire. Although the studies have been useful in painting a picture about the level of stress that junior doctors encounter, they do not delve in depth into what would help to reduce job stress levels and support doctors to stay in the profession. There is a need to experiment with and evaluate new ideas that help retain staff through support, better career development and improved working conditions. My study was able to explore the perceived benefits of an interprofessional approach to mentoring that aimed to support new staff during the first six months of their practice and help them with their professional and personal development.

In summary, stress and anxiety based on workload, change in role, responsibility and accountability, and working with other professional groups and patients were highly emotive for PRHOs. This was acknowledged by senior medical and nursing staff. Not only did these stressors affect their work but they also had implications for the retention of staff, which is a major problem within the health service. These stressors were both internal (own feelings and abilities) and external (other individuals and work requirements).

Participants acknowledged that they had to find their own ways of coping with the stress they experienced. This also seemed to be linked with personality (i.e. Type A or B) and the concept of locus of control. However, junior doctors strongly advocated and called for support from senior staff (all professional groups) and the Trust, with mechanisms to help them cope with stresses they experience, as well as supporting their personal and professional development.

5.1.2 Learning to become a professional

From the views expressed by participants, learning became a major contributor to becoming a practitioner. Learning took place both in relation to self and to others. Participants mentioned how they had to learn about their role and what was expected of them, and develop their practical skills, as well as learn to work and interact with others and develop relationships with other practitioners. It became clear that learning was a process that incorporated both aspects at the same time, i.e. self and others. Initially, however, PRHOs were more concerned with the practical side of their work and with learning in relation to themselves. For example, they needed to know what to do on a day-to-day basis, to find ways of managing their work and to learn about practice in relation to the theory learnt in medical school. Therefore, this section will examine the concept of learning in relation to self. Learning in relation to others, such as collaboration and communication, will be discussed later in the chapter as it is part of the socialisation process for junior staff. Learning was not exclusive to junior doctors in this study since the mentors believed that they too learnt from the process of mentoring another professional group.

Learning was both theoretical and practical but for PRHOs the latter was of greater concern. Mentors, mentees and clinical tutors all realised that there was a gap between theory and practice for junior staff as is also stated in the literature (Weller 2004). Although PRHOs knew the theory behind most aspects of their clinical practice, they expressed the lack of hands-on experience during their training. Some clinical procedures that caused concern to many were drug calculation and administration, suturing, catheterisation and inserting nasogastric tubes. This perceived or actual lack of practical experience could be partially or completely attributed to the inadequacy of training for medical and nursing staff. Studies by Grainger (1997) and Jones et

al. (2001) concluded that PRHOs are not adequately prepared for the clinical work they undertake as junior doctors. However, Clark (1994) argues that it would not be possible to structure the acquisition of all skills required for junior doctors due to the nature and variety of their work.

The study by Jones et al. (2001) consisted of postal questionnaires developed on the competencies defined by the GMC (1997), which were sent to 256 PRHOs three months into their first post and to 194 educational supervisors responsible for supervision of graduates. Their study showed that PRHOs were not prepared for some fundamental aspects of their post such as diagnosing, decision-making and provision of treatment, including prescribing. There were limitations to the study, which they themselves identified i.e. slightly different phrasing of the questionnaires for the two groups, thereby limiting statistical testing and making such tests inappropriate. They mentioned how the views of PRHOs may have been influenced by practice and that their answers about preparation for practice at medical school may not be a true reflection of how they had been prepared. It would have been beneficial if the researchers had administered the questionnaires immediately after finishing medical school and then repeated the process 3–6 months later for comparison. I believe this would have been more advantageous and provided evidence about the level of learning that occurs during the first few months of practice, as referred to by participants in my study.

The GMC (2005), in their document *The New Doctor*, defined the general clinical training that takes place in the PRHO year as being the final year of basic medical education, and in their 2003 document *Tomorrow's Doctors* the GMC places the responsibiltiy of education on both medical schools and NHS Trusts. This is not always acknowledged by staff on the wards. Dent and Gillard (1998) advocated that junior doctors have very little medical expertise and require close supervision by senior medical and nursing staff. This demonstrates that less should be expected of junior doctors when they enter the workforce and reinforces the need for support in the initial few months to help them acquire those basic clinical skills (Jones et al. 2001). This also demonstrates how medical schools provide students with the knowledge but fail to provide adequate opportunities for the acquisition of practical skills and experience. Therefore, the pre-registration year is not only a time of working

but is also the time of greatest learning for junior doctors. The points highlighted above from the literature validate the findings of my study. Many participants in this study claimed that PRHOs have the theoretical knowledge but need time to develop their practice. It is, therefore, regrettable that PRHOs were so hard on themselves and believed that more was expected of them when clearly the house officer year should still be considered a training year.

Occasionally there were additional expectations of PRHOs by some nurses, particularly junior nurses, but according to participants this was mainly attributed to the nurses' lack of knowledge about the training of doctors. An additional pressure for PRHOs is that they are the first to be called in emergency situations or are the professionals expected to talk to the families of dying patients when clearly many nurses have greater practical experience. Participants in this study also highlighted the flaws in the health system whereby PRHOs have to be called when experienced nurses have difficulty undertaking certain clinical procedures such as catheterisation or inserting nasogastric tubes. PRHOs, who probably have far less experience and have either only observed the clinical procedure or carried it out a few times themselves, would be expected to resolve the clinical situation despite the difficulties of a far more experienced health professional. It may be necessary to re-evaluate how the health system makes use of individual talents and experiences or provides appropriate support structures. These additional pressures placed on PRHOs were not always conducive to learning.

Medical schools still retain a certain pedagogical approach to learning and teaching that does not adequately prepare junior doctors for practice (Bleakley 2002). PRHOs mentioned utilising several ways of learning. First was the ability to ask questions at any time and without fear of ridicule. Many PRHOs mentioned how they found nurses to be more helpful and accessable than the senior members of their own team. Second was the need to observe or be observed while carrying out clinical procedures or making decisions about patient care (i.e. patient management). There were mixed views about this amongst the junior doctors. Some felt that only senior doctors were able to help with this aspect of their learning needs whilst others believed that senior nurses, such as nurse practitioners, were adequately able, knowledgeable and experienced to support them with patient management.

The attitudes about who can teach junior doctors, could be reflective of the history of medical education which has traditionally had a pedagogical approach with an emphasis on theoretical and scientific knowledge. However, in the last 20 years there has been a re-examination of this approach in medical education resulting in calls for more clinical exposure during training (Towle 1998). In 1993, the General Medical Council identified the main challenge facing the undergraduate curriculum as finding ways of reducing factual overload and the nurturing of adult learners with the ability to critically think and evaluate evidence. Towle suggests that many of the reforms in medical education today aim to reduce the theoretical load in favour of the acquisition of general competencies, including promotion of life-long learning and multiprofessional working, with more emphasis on clinical and practice-based learning, which requires a change in attitude and practice for medicine. In the curriculum for the foundation years for postgraduate education and training (The Foundation Programme Committee of the Academy of Medical Royal Colleges 2005), and the GMC 2005 document, '*The New Docotor'*, some of the key features are on team working, multi-professional practice, effective communication, effective relationship with patients, good clinical skills, continuing professional development and lifelong learning. These themes become the focus of the training of junior doctors in the pratice area. Mann (2002) suggests that the clinical setting is as much the learning environment as the classroom. She advocates that, in practice, even if individuals do not experience everything firsthand in order to learn, they can learn through observation of others where they not only see the action of others but also the effects of that action. Therefore, having someone in practice that they can observe is important for students and was something called for by participants in my study. PRHOs commented on how, in many instances, they were able to observe nurses carrying out certain procedures and learn from it. Nurse mentors also commented on how they had identified clinical skills that PRHOs lacked and ensured that the junior doctors could observe or carry out the procedure under observation. This was very beneficial for the PRHOs in the early days.

It can be concluded that learning is a continuum rather than a series of one-off activities, which is, in my view, what is being offered to healthcare

professionals today. Within medicine, changes have been made to the training and education of new doctors by the development and piloting of foundation programmes beginning in 2005. These programmes consist of two years of integrated and planned training incorporating the PRHO year and the first year of post-registration. They involve closer supervision, compulsory study days and more practice experience in different specialities. This is a positive move since healthcare professionals should be in learning mode from the moment they enter university to the time they retire, with opportunities and programmes to help develop this attitude to learning. This is what is required in terms of continuing professional development and life-long learning as promoted by the Government and medical governing bodies (GMC 2005, DOH 2000a, 2000b, 1999, 1997).

In its working document about developing the NHS workforce (DOH 2000c), the Government advocates that NHS Trusts should gear their thinking and resources towards supporting greater career flexibility and the development of additional skills for staff as strategies for continuing professional development and life-long learning. Using an interprofessional approach to assist this is an option to ensure that learning becomes a continuum that supports practice. This would also support the call by the Government for more collaborative working and learning environments (DoH 2000c, 1997). By this it is meant that learning does not occur uni-professionally with the focus on what 'I' the individual doctor or nurse does but rather in terms of what 'we' as healthcare professionals can do, with the provision of care becoming central instead of the profession. My study, however, demonstrated that many professionals still have a uni-professional attitude to both education and work. Mentees mentioned how they had to learn from doctors about medical management and how that was more important for them. Mentors too mentioned that junior nurses would not be able to learn much from senior doctors who had little knowledge of the educational needs of nursing staff. However, interprofessional learning and working was still strongly advocated by most participants in this study, where the well-being of patients become the common goal for all staff to work towards. This again demonstrates the lack of clarity about the term interprofessional and the need for more experimentation to find the best interprofessional approach to health care and education.

Continuing professional development has become a necessity for individual practitioners in the current climate and an increasingly organised aspect of many professional groups, with an emphasis on mentoring. In my view, learning is a word that encapsulates the purpose of mentoring and continuing professional development. The whole process is about becoming a more knowledgeable and experienced practitioner and this is best achieved through a learning posture and attitude. Therefore, the purpose of mentoring becomes one of individual learning and growth, and this learning is then passed on to subsequent generations. For example, junior doctors who are mentored and supported to grow personally and professionally will themselves develop the skills required to be able to mentor other junior staff as they become more senior. The process of mentoring then prepares professionals for life-long learning. This applies to both the mentee and the mentor, who develop and learn from their interaction and relationship with each other. Davies (1999) suggests that new graduates bring with them new and contemporary ideas that aid the mentor in keeping up-to-date with their own professional knowledge, and that they each gain something different from the relationship and experience depending on their needs and their stage of growth. Mentors in my study acknowledged this and mentioned how they too learnt from mentoring and the relationship they developed with students or new practitioners. A few nurse practitioners mentioned how PRHOs taught them to identify heart murmurs during medical examinations or read an electrocardiogram (ECG). This suggests that learning and mentoring are parallel processes, which are most effective when the attitude of mentor and mentee are aligned. In this study, the interprofessional angle contributed an added learning outcome: that of learning from, with and about another profession. This was clear from what each participant shared during the interview about the experience of mentoring. Table 9 demonstrates the varying degrees of learning by participants, and their learning mode in relation to their experience with another professional group.

Partici-pants	Learning achieved	Learning mode
PRHO Type 1	• Able and willing to ask for help • Finds nursing staff a source of knowledge and experience • Observes and learns new skills from nurses • Better able to communicate and interact with nursing staff • Gains greater understanding of role and contribution of other professionals, particularly nurses • Able to support junior nurses and thereby learn as a mentor as well as a mentee	• Willing to participate • Willing to learn from other professional groups • Open to new working practices
PRHO Type 2	• Learns those new skills they feel they can learn from nursing staff • Gains some understanding of nursing roles • Will ask for help when they feel they have to	• Has some appreciation of the contribution of others • Knows they could learn from others • Will take part but on own terms
PRHO Type 3	• Develops a seniority attitude towards nurses due to minimal interaction • Learns what nurses do	• Does not feel that nursing staff can help with their personal or professional development • Unwilling to take part
Mentor Type 1	• Learns about the training of PRHOs and their learning needs once in practice • Understands the stresses that junior doctors are under and support they receive from their own team • Learns new skills from PRHOs, e.g. diagnosing heart murmurs • Learns new skills of working closely with another professional group • Learns new skills in empowering a mentee to learn and develop	• Learns and grows from helping others learn • Believes they can contribute to the learning of others • Has experience in empowering others to develop and achieve their learning goals • Willing to take part as they understand the contribution to health care

Mentor Type 2	• Has a greater awareness of the training and needs of PRHOs • Learns to support if the PRHO makes the approach • Gains some new skills in interacting more closely with medical staff	• Will take part with hesitation and reluctance • Uncertain what they can contribute and how they can help PRHOs
Mentor Type 3	• Does not feel it is their duty or responsibility to support other professionals • Does not feel they can learn or benefit from closer interaction with medical staff	• Unwilling to take part • Does not see mentoring other professionals as being part of their role • Can cause obstacles for others

Table 9. The degrees and mode of learning for participants

Knowing about what people do and learning about their role are two separate issues. It is easy to list the activities of one profession but to really understand their role means to learn about the function they serve in carrying out those actions. Furthermore, a deeper learning occurs when one professional understands the roles of others and appreciates and respects the level of contribution they make to health care.

In summary, learning the practical aspects of their job was initially a major factor for PRHOs. They believed they could overcome the issues by observing others and having access to senior staff to ask questions and receive guidance. Nursing staff were perceived as the professionals who could best support and contribute to the learning of junior doctors but there were mixed views about the extent to which this cross-professional teaching and support could occur. Both mentors and mentees learnt from the experience of interprofessional mentoring, which can aid an individual's life-long learning. The learning that was achieved depended on the approach and willingness of the individual practitioner. Participants acknowledged that interprofessional mentoring contributes to the learning process and to the coping ability of junior doctors, as discussed in the next section.

5.1.3 The contribution of interprofessional mentoring to learning and coping with stress

Findings from this study suggest that support is required to meet the needs of junior staff in their early days of practice and that interprofessional mentoring can provide that support. Participants in this study acknowledged and asked for structures to be in place to support them during this time, as well as to contribute to their personal and professional development. Although structures (e.g. educational supervisors, clinical tutors) were in place, many participants believed them to be insufficient. Participants acknowledged that individuals differ in their personality, abilities and behaviour, therefore necessitating a variety of support mechanisms to meet the diversity of needs. As Wilson (2004) states, no one person can provide for all needs, especially as these needs change at each stage of development. Participants acknowledged that interprofessional mentoring provided them with extra support, a different perspective on patient care, confidential advice, supervision of clinical practice and experience in dealing with other professional groups and patients. These are all part of the learning needs of a new practitioner.

It was interesting that what PRHOs believed to be important for their learning was also what they perceived as necessary to help them with their anxieties in the early days of their practice:

- Lack of practical experience impacted on the confidence of the junior doctors causing anxiety and stress, and skills needed to be learnt in the first few weeks in practice;
- Accessibility to senior staff with the knowledge and expertise to help them with clinical work such as patient management, decision-making, drug calculation and administration, clinical procedures and dealing with other staff and patients. This aided learning and eventually gave them the confidence and ability to carry out their work effectively, thereby reducing their stress levels;
- Being able to observe others or be observed in relation to decision-making, clinical procedures and dealing with staff and patients. This too impacted on learning and confidence building.

It became clear that learning to be a practitioner and developing the skills needed for practice were the major contributors to helping alleviate stress levels in this study. Examples given by participants included learning to manage workload, which was identified as a major cause of stress, either by observing other doctors or through time and experience; and having access to an approachable, experienced practitioner, which meant they could have worries and queries resolved straight away, thus reducing their stress level, enhancing their learning and allowing for better management of their work.

An identified purpose of mentoring is professional development (Ramanan et al. 2006). In their survey study with 329 junior doctors they concluded that mentored doctors were nearly twice as likely to describe excellent career preparation. Although there was an expectation that mentors would be able to help mentees with their professional development, this was more in the form of teaching them clinical skills or providing the opportunity by creating a learning environment. Kuhl Bary and Kaneko (2002) suggest that effective mentoring is about professional empowerment to allow the mentee to feel confident in their abilities and their decision-making. More professional specific learning would need to be met by members of that professional group itself. Nevertheless, to a great extent, experienced nurses, especially nurse practitioners or nurse consultants, have through their practice developed a very good understanding of the medical management of patients and would be able to provide some insight for junior doctors. The purpose of this mentoring scheme was not to replace the existing support and educational system for PRHOs, but to enhance the system by providing additional support, a means for junior doctors to gain insight into another professional group's contribution to health care and develop the skills to work collaboratively with other professions. Uni-professional mentoring would not provide this additional learning experience.

There are currently only two official support systems in place for PRHOs: educational supervisors and clinical tutors. According to interviewees, besides these mechanisms, other support received by PRHOs from medical or nursing staff has always been ad hoc and dependent on the individuals and employing institution. The PRHOs in this study described their approach to obtaining support or answers to their questions by identifying individuals who they believed to be approachable and able to help, which for some was an arduous

task. It can be suggested that those with an internal locus of control would not find this approach difficult but those doctors with an external locus of control found approaching senior staff for help challenging. This was mentioned by some PRHOs who either found it hard themselves or observed their peers struggling to obtain support. However, educational supervisors shared how they had gone through the same process, which was in essence part of the socialisation into and experience of the profession, and some did not see anything wrong with that. Durkheim (1938), in his book *The Rules of Sociological Method,* indicates that it is wrong to assume that just because something exists in society it is normal and should continue. It is interesting that nearly 70 years on some medical staff still have the veiw that if they experiencd hardship, it is, therefore, a normal part of training and socialisation for new staff. This issue has been acknowledged now by the medical profession, and mechanisms to decrease the stress on PRHOs are being introduced, e.g. reduction in working hours across the board and more mentoring opportunities in some areas.

Obtaining answers about clinical matters or the way the organisation functions, or knowing how to deal with colleagues (particularly from a different profession) and patients, were ways of decreasing the stress levels, according to many interviewees. This, therefore, meant that accessibility and knowledge of both the clinical practice and the functioning of the organisation were deemed important characteristics of a good mentor. Although senior doctors had the knowledge, on many occasions they were inaccessible due to theatre and outpatient clinic commitments. Another form of support that all PRHOs commented on came from their peers (fellow PRHOs) who were accessible, good listeners and sympathetic as they too had similar experiences to share. Revicki et al. (1997) also found in his study that peer support was a major contributor to coping with stress for medical staff. His survey study of 484 emergency medicine residents from their first through to third year concluded that residents who believed that they had support from their peers and co-workers perceived less stress, reported fewer symptoms of depression, and were more satisfied with their work. However, peers were only able to give emotional support since they too lacked experience and knowledge of both the clinical practice and the organisation.

What made mentoring from a senior nurse more beneficial were the constructive ideas they had for dealing with stressors. For example, one PRHO commented on how the nurse mentor was able to help him with difficulties he encountered with some nurses. This was as a result of her knowledge of nursing staff, which the PRHO's peers lacked. Senior nursing staff were generally more accessible (on the same ward) than senior doctors and had more experience and knowledge than the house officers' peers, thereby making them an excellent resource for junior staff. This simple action of talking and listening is part of the process of reducing stress (Hardy and Thomas 1998). Hardy and Thomas advocate that people are more satisfied when there are good interpersonal relationships between staff and suggested establishing small support groups within the workplace.

Defining the role of mentor as being of a supportive and facilitative nature meant that finding the best person would need careful consideration. Mentors in this study understood mentoring to be a way of supporting student nurses in practice and teaching them the clinical skills they require. This was similar to the experiences of junior doctors in relation to their educational supervisor, but they perceived them to be more responsible for assessment of their competency as a doctor rather than as a mentor, especially as most educational supervisors were also the employers of PRHOs. Kuhl Barry and Kaneko (2002) described a mentoring scheme for school site administrators where the aim of mentoring was one of support only; therefore, the mentor should preferably not be a line manager who has the responsibility of assessment (Cole 2003). This was further supported by the findings from the questionnaire in this study where the four professionals that increased the stress levels of PRHOs the most were educational supervisors, consultants, registrars and junior nurses. It is understandable that the inexperience of junior nurses could cause problems for PRHOs. Examples given were junior nurses lacking the right information about patients or bleeping junior doctors unnecessarily. Concern comes from the other three identified groups who are effectively responsible for the personal and professional development of junior doctors and for supervising and supporting them in practice. It has to be highlighted that the questionnaire did not distinguish between registrars and consultants of the PRHO's own team or other teams that they occasionally interact with, for specialist consultation.

However, from the interviews it became clear that an increase in stress levels and a lack of support came from the PRHOs' own medical team since some would not go to their supervisors or senior team members with worries or problems for fear of repercussions for their assessment.

Allen (2000) agrees that junior doctors fear speaking out because of possible consequences for future references. Wilson (2004) also sees the culture of medicine as an obstacle to mentoring. Wilson states that the medical culture does not encourage the seeking of help, and new staff are often unwilling to admit that they need help or have problems. The issues of one person acting as both assessor and mentor/supporter also became a problem in nursing. Even though the English National Board (ENB) in general tried to distinguish between and encourage separation in the roles of mentor and assessor in most practice settings, the roles are usually carried out by the same individual. In the document '*Preparation of mentors and teacher*' prepared by the ENB and DoH (2001) the role of the mentor is described as facilitator for learning, supervisor and assessor. For this reason they stress the importance of students determining which role the mentor is undertaking at any given time. Brockbank and Beech (1999) suggest that mentors can find that the dual roles of supporter and assessor cause conflict, and as mentoring progresses some mentees become uneasy about the influence, power and authority of an assigned mentor. This was also emphasised by the mentors who believed that new staff and/or students need to have someone they can turn to without worrying about being judged. This highlights the need for a safe environment for learning and growth where mentees have the freedom to express their needs and share what they believe they are lacking in knowledge and skills (Clutterbuck 2001). For this to happen, it is imperative that the person with the responsibility for the appraisal of staff should not act as mentor. Therefore, the idea of nurses acting as mentors for junior doctors and having no influence on their assessment became a positive aspect of this project.

In the case of medicine, although educational supervisors have a mentoring role, the nature of their function includes assessment of the competency of PRHOs for their registeration, and even the title itself indicates supervision and overseeing the actions of junior doctors. Freeman (1998) explains that whilst there is a reassuring element of directing and guiding, an autocratic aspect is

equally necessary. This makes the relationship between the two individuals more complicated and less equal if the supervisor/mentor is expected to make an assessment and judgement about the other individual. This was mentioned by many participants who believed that junior doctors would not always go to their educational supervisor for help if they believed or perceived it could impact on their registration as a doctor. In addition, educational supervisors were the employers of the junior doctors, which added another dimension to the relationship and further prevented that collaborative interaction required between mentor and mentee.

Clinical tutors also have as their role the support of PRHOs in addition to the organisation of the educational programmes for the registration of doctors. This again has flaws as mentioned by clinical tutors themselves. Only a small percentage of their time is allocated to this role and they have the responsibility of all the PRHOs. Because mentoring is a close, one-to-one relationship between two people, it would be practically impossible for one individual to build such a relationship with 20 to 30 individuals in a one day a week work allocation. Therefore, there needs to be another support structure to complement the role of educational supervisor and clinical tutor. Most participants remarked that junior doctors naturally turn to nurses on the wards for support and advice in an informal way. Therefore, having a nurse mentor was seen as a viable way to support junior doctors by many interviewees. There was the added benefit of allowing the professional groups to understand more about each other's roles and responsibilities and be able to develop closer interpersonal and working relationships.

It was acknowledged that, as time goes on, the mentoring role changes as the needs of the mentee change. Initially, junior doctors needed general information about the organisation, like request forms, location of departments and carrying out routine procedures. They then needed to learn how to interact with other professional groups. As their confidence grew, they required more specialised support, such as teaching of complex clinical tasks or career advice. This demonstrates that mentoring is a multifaceted process, closely linked to continuing professional development, which becomes more complex as professionals grow into their roles. This has two implications: first, that the qualities and skills of a mentor have to be diverse, and second, that no one

person may have all the necessary qualities, expertise and knowledge to mentor someone as they develop. This was demonstrated by the comments of junior doctors about approaching different individuals (i.e. senior doctors and nurses) to help them with different aspects of their professional and personal development.

It became clear that the development of mentees was in different stages and their needs as well as the role of the mentor varied according to the stages. Table 10 demonstrates the process of mentoring, which is closely linked to learning and development.

	Mentee's needs	**Mentor's role**	**Learning outcome for mentee**
Stage one	Orientation to practice setting	Teacher	Organisational awareness
	Practice of basic skills	Teacher	Skills acquisition
	Sharing concerns and fears	Counsellor/ confidant	Personal crisis management
	Managing workload	Supporter and role model	Socialisation
Stage two	Advanced clinical skills	Advanced teacher	Mastering the speciality
	Developing interpersonal skills	Supporter and role model	Socialisation
	Decision-making	Colleague/advisor	Becoming professional
	Applying advanced theoretical knowledge to practice	Tutor	Knowledge acquisition
Stage three	Teaching others	Role model	Becoming a mentor
	Leadership skills	Leader	Becoming a leader
	Assessment	Supervisor	Becoming competent
	Career choices	Career advisor/ patron	Making choices

Table 10. Process of mentoring and learning derived from this study

How quickly individuals go through the stages of this process depends on the individual's capacities and volition, and the support received from others in the organisation (i.e. management, staff and mentor).

Because the mentoring of PRHOs by senior nurses in a formal setting was a new process, with uncertainties about the concept of mentoring and the relationships between mentors and mentees, the areas in which nurse mentors could support and help PRHOs were unclear for some and thereby impacted on the approach and attitude of both parties. For example, some mentors did not understand PRHOs' needs and so lacked the confidence to allow junior doctors to set their own objectives and what they required for their growth. Freeman (1998) describes similar findings in her study with coordinators of five mentoring projects with general practitioners. She found that a lack of clarity and uncertainty about the exact role of mentors meant that the needs of the mentee were overshadowed by the needs of the mentor to direct the work of the mentee rather than allowing them to set the agenda for discussin and action. Another example, is how some mentees did not fully appreciate what they could gain from their relationship with a nurse and its impact on their professional development, thus not making use of the opportunity for support provided. This problem could be attributed to the interprofessional approach of this study, but I believe it is also influenced by a lack of experience of the mentoring process within the medical profession as also stated by Freeman (1998). More recently in 2003, Ehrich et al. presented a paper at the British Educational Research Association Annual Conference, in which they asserted on the basis of the literature that although much has been written anecdotally about mentoring in medicine, there is very little research based literature. They conclude that there is little evidence of examplars of mentoring in the medical context.

Nurse practitioners (NPs) were mentioned by many interviewees in this study as the most effective group of professionals to act as mentors due to the nature of their role. Nurse practitioners are experienced nurses who have advanced their clinical practice and taken on additional responsibilities, many of which have traditionally belonged to the medical profession (Easton et al. 2004). They were able to meet all the aims of mentoring identified in this study, as demonstrated in Table 11.

Aims of interprofessional mentoring as identified in this study	**NPs' contribution to the aims of interprofessional mentoring**
Partnership between two people built on trust	The nature of the relationship between PRHOs and NPs means they have to work closely together to share the workload. This means they develop a close working relationship that has to naturally involve trust, respect and support. Although this does not always occur between the individuals, most NPs mentioned having developed this relationship with the PRHOs.
Process providing ongoing support and development opportunities	NPs mentioned how, in most instances, they previously had to support the PRHOs simply because they had to divide the workload and manage their own work. Therefore, they found themselves having to answer many questions or observe PRHOs in practice. A couple of NPs also mentioned how they would call PRHOs if they were aware that they needed to observe a particular clinical skill.
Two-way learning relationship	Mentees commented on the experience of NPs, from whom they learnt many practical aspects of their jobs and role. They even mentioned how NPs were able to familiarise them with the working of the medical team they had joined. NPs also believed they learnt from PRHOs who may have more access to teaching opportunities due to the nature of their position. Examples included PRHOs helping NPs diagnose heart murmurs, and PRHOs reviewing blood results with NPs following a teaching session.
Fostering capacity of mentee to the point of self-reliance	NPs mentioned how, in the course of their relationship, they would guide the PRHOs until they were able to manage and organise their own workload. This also made the relationship more equal once the PRHO reached that stage of independence.

Fostering relationships with other professional groups and understanding their roles and responsibilities.	NPs were perceived by many participants as a group that crossed both professional boundaries. With a nursing background, they were fully aware of the roles, responsibilities, training and pressures of nurses. Due to the nature of their role, NPs work very closely with doctors, thereby giving them more insight into the world of medicine. This allows NPs to bridge the gap between medical and nursing staff, which has at times been problematic. Mentors and mentees both commented on how NPs had a good understanding of the stresses that each professional group encounters and were able to support both groups as a result. Some mentees explained how their mentors had been able to help them in dealing with nurses, especially when there had been a clash of ideas or personalities (26% of mentees found the nurse mentors helped them reduce the stresses experienced in working with nurses). Therefore, NPs are the most suitable professional group to act as mentors due to the nature of their role and experience.
Accessibility	Because accessibility was a major requirement in providing support and teaching for PRHOs, it was necessary to find individuals who could be contacted easily and who preferably work in the same place or have a close working relationship. Again, NPs had to work in partnership with PRHOs as part of their role, which meant they had to contact each other regularly, share work and meet frequently. Therefore, they were readily accessible and ideal to act as mentors.
Observing and teaching clinical skills	Most NP mentors identified many occasions when they either demonstrated or observed PRHOs carrying out clinical work and procedures. This ranged from observing them filling in request forms, to administrating intravenous medication. Some saw this as a natural part of their job, although others did not accept the teaching of medical staff as part of their nurse practitioner role.

Table 11. NPs' contribution to the aims of interprofessional mentoring

Although NPs appeared to be the most suitable, competent and experienced group of practitioners to take on the challenges of cross professional mentoring, there were still issues to face. With any mentoring relationship, there is a need for some interpersonal skills which not all individuals naturally possess. All participants commented that the mentor and mentee should get on as individuals and not have a clash of personalities. NPs were not excluded from this possible problem. In addition, the role of NPs and their training vary from health authority to health authority, from hospital to hospital and even from ward to ward, depending on the consultants whose team the NP works with or the university at which they received their NP training and education. Some NPs in the Trusts involved in this study had adopted a medical model for their practice as well as completely divorcing themselves from the nursing staff. Some ward-based nurse mentors expressed how NPs were not part of the nursing team but belonged to the medical team and did not contribute to nursing care. In other Trusts, both NPs and ward nurses perceived NPs as being part of the nursing team but who worked more closely with the medical team and provided the much-needed bond between the two professional groups.

According to Worster et al. (2005) the NP offers a combination of expanded nursing expertise, where nurse training is required and nursing abilities called on, and extended proficiency in tasks that are essentially medical where nursing is not a prerequisite. Therefore, they can cross the professional boundaries with regards to their clinical practice and working relationships. However, Andrewes et al.'s (1999) review of the literature still demonstrates the ambiguity around the work of NPs. They state that a lack of clarity about the role of the NP and its relation to the general nursing role make any benefits of NP role unclear and often dubious. Andrewes et al's qualitative study involved 38 NP students at varying stages of their studies on a NP foundation course, as well as three nominated doctors and a qualified NP. Participants in their study were divided in their opinions about the contribution NPs make to health care and across the different disciplines and specialisations. Interestingly, they found that younger medical staff were in favour of NPs. However, generally the definition of NPs and their recognition by other staff and integration into the system (which needs time to develop) were seen as problematic. Dickson (1996) states that general nurses see NPs as substitute

doctors or physician's assistants thus weakening their identity as nurses. Andrewes et al.'s (1999) study also expressed caution about NPs losing their nursing skills. Such a scenario would have further implications for interprofessional mentoring in that junior doctors would not gain a full understanding of the nursing role. This also became evident in my study, whereby some participants (e.g. nurses, project leads) mentioned how, in their Trust, the NPs were completely detached from the nursing staff and management and were perceived as part of the medical team. A few nurses also mentioned how NPs' interactions with ward nurses had become similar to that of doctors. This was not a universal opinion and, in some cases, NPs were viewed as members of the nursing team who had expertise and were called on to deal with many aspects of patient care instead of doctors. However, Easton et al. (2004) suggest that this is changing, that is nurse practitioners are advancing their roles but with a more nursing focus.

A criticism of Andrewes et al.'s study is the lack of clarity about the level of interaction the doctors interviewed had with NPs and, because the doctors were recruited through self-nomination, it could be viewed as a biased sample. Also, interviews with more doctors and professionals allied to medicine (PAMs) who had experience of working closely with NPs would have been beneficial and more illuminating.

What makes interprofessional mentoring different and more beneficial than uni-professional mentoring is the environment that it creates. Nurse mentors were able to help PRHOs deal with the stressors caused by both nursing and medical staff in several ways:

- Becoming aware of the way nurses practice and work, thereby understanding how to work with them more productively;
- Developing more interpersonal and communication skills with nurses;
- Seeing nurses as professionals who possess knowledge and experience, which they are able to share with junior doctors;
- Being able to access someone that is on the wards more regularly than their own team members;

- Being able to express their worries and lack of practical experience or theoretical knowledge without the anxiety of jeopardising their registration.

Witnessing that nurse mentors can help PRHOs in practice and in developing a close relationship with them caused a change in both the working environment and in the attitude of junior doctors towards nurses. According to many PRHOs, this was helpful in reducing some of the stresses they experienced, particularly in the early days of their practice. As far back as 1976 Moos theorised that people are more satisfied and tend to perform better in an environment where interpersonal relationships are emphasised, for example, through staff support or sensitivity groups, where staff are encouraged to meet together and share their work experiences, listen to each other and provide shared opportunities for learning and developing through problem solving and support. Interprofessional mentoring, especially when a junior nurse and junior doctor are mentored jointly by a senior nurse, functions as such a group. An example of this was when a junior doctor and nurse, with the support of the mentor, solved the difficulties that the junior doctor was having with his workload and relationship with his medical team (see Appendix F). The junior nurse also identified where she could support and help the PRHO, thereby not only learning more about how medical staff work but also developing a much closer relationship between them. This would not have been possible if mentoring for junior doctors was provided only by other medical staff. NPs who have a good understanding of the working patterns and responsibilities of both professional groups naturally become the best individuals to act as mentors within such an approach.

In summary, from this study, it was evident that being newly qualified was a challenging time for most PRHOs and a steep learning experience. The findings of this study correspond with Charney's (1999) analysis of four key areas that encompass the stress of being newly qualified: the reality of practice, learning the system of the ward, developing clinical judgement, and developing professional relationships. PRHOs needed to develop and learn the necessary skills and knowledge to overcome the above mentioned areas and so reduce their stress.

Learning became the major focus of mentoring, through support, empowerment and facilitation by the mentor. Individuals who have the role of assessing junior staff may not be in the best position to fulfil the role of a mentor as outlined in this study. However, due to the complexity of the needs of junior staff, having access to a variety of support mechanisms is crucial. Nurse practitioners have been identified as a key group able to cross the professional boundaries and mentor junior doctors.

This study identified a number of advantages to interprofessional mentoring: the ability of the two professional groups to develop a closer working relationship, and thus increase the awareness and understanding of the roles and responsibilities of their respective professions. Further, it allowed for someone from a different professional group to be readily available who could be approached in confidence without generating any fear of repercussions regarding assessment and final registration. In addition, having someone who understood nursing training and the way nurses function on the wards was seen as beneficial. It allowed the junior doctors to interact more constructively with nurses as a result. This increase in understanding about the roles and responsibilities as well as the stressors encountered by each professional group, ultimately helped their interpersonal and working relationships. In turn, the participants (particularly mentors) believed this lead to improved communication and ultimately, patient care. (The issue of communication is discussed later in this chapter).

5.2 The journey of becoming a professional in relation to others

As participants shared their views on the advantages of and challenges to interprofessional mentoring, issues such as socialisation, culture, identity, power, collaboration and communication were raised. Once junior staff had become secure and confident in their ability to undertake the day-to-day aspects of their own practice, they needed to learn to deal with any external influences on their work, such as their relationships with others and communication skills. This involved socialisation not only into the

participants' own profession but also into the organisation and the culture of the health service. The process of socialisation involves learning to collaborate and communicate with a variety of individuals, such as patients, relatives and other professional groups.

In this section I explore how interprofessional mentoring enhances the learning process for junior doctors in their training to become practitioners in relation to socialisation, collaboration and communication.

5.2.1 Socialisation into the profession

This section looks at the views of participants on the process of socialisation into the profession. The areas highlighted by participants as discussed here were the role of the individual in their socialisation, the impact of culture on socialisation and the role of others on the socialisation of students and newcomers. Part of the journey of socialisation is the development of an identity. To date, the process of socialisation has been uni-professional. This section demonstrates how an interprofessional mentoring programme can influence the culture of the work environment, which in turn changes the socialisation process for junior staff and affects their identities that are being formed.

Most participants in this study acknowledged the substantial learning experience that occurs for newly-qualified staff during the first months of their practice. Many mentioned that they learnt quickly what it meant to be a doctor and what was expected of them, i.e. how to act or behave. Becoming a practitioner involves more than just learning certain knowledge and skills; it involves socialisation into the profession and the working environment through learning from role models and through observation of other people's practice (Melia 1987, Bucher and Stelling 1977). Learning to become a professional also means learning to fit into the culture of that profession. Merton et al. (1957) describe socialisation into a profession occuring as a result of learning and aquiring the values, attitudes, interests, skills and knowledge, in short the culture, of the profession they have entered.

During the process of socialisation, practitioners also develop their identity as professionals, which the participants believed is governed by the culture and environment in which they were situated. Principally, junior staff usually enter

their profession by working closely with a senior member of staff (within both educational and clinical settings) or by role modelling themselves on someone they believe to be a good practitioner (Bucher and Stelling 1977). Table 12 demonstrates the course of socialisation for a new graduate based on the findings from this study.

Socialisation process	Learning gained from the process	Influenced by
Enter training The individual enters the culture of their profession and health care, and begins to learn and develop attitudes and values based on that profession. This process ultimately leads to the development of their own identity.	• Mainly theoretical • Beginning to identify characteristics of the profession • Forming collegiality with others in the same profession • Learning professional values	• Peers • Teachers
Enter practice setting The individual enters the culture of the practice setting and begins to learn and develop attitudes and values based on their profession. This process ultimately leads to the development of their own identity.	• Developing practical skills • Learning to interact and communicate with other professional groups • Connecting more with own profession and its component parts • Developing the values and attitudes attributed to that profession	• Peers • Nurses • Doctors • PAMs • Observation • Role modelling • Emulating
Enter organisation The individual enters the culture of their profession and health care, and begins to learn and develop attitudes and values based on that profession. This process ultimately leads to the development of their own identity.	• Learning to function in an organisation • Learning about the role their profession plays in the organisation	• Other practitioners • Policies and procedures

Enter profession Through this journey, professional identity has developed along with a sense of belonging to and acceptance in the profession	• Learning to be a professional • Developing expertise • Contributing to the profession	• Peers • Professional colleagues • Other professionals • Professional bodies

Table 12. The course of socialisation for new graduates

Participants acknowledged how this process begins at the start of training, where nurses and doctors learn the values and attitudes of their profession, and continues throughout their careers but in different formats. Major works in this area have been by Merton et al. (1957), Becker et al. (1961), Olesen and Whittacker (1968), Bucher and Stelling (1977) and Melia (1987), which are still used today because of their relevance. The former four studies were with undergraduate medical and nursing students and the latter on post-graduate medical education – their findings had similarities with and informed the findings of my study. Although my study was with junior doctors, their first year of practice is considered to be part of their training (GMC 2005) and so the findings of the above-mentioned studies were relevant to my study.

Much of the early work in socialisation, particularly with doctors and nurses, suggested that a profession exists as a powerful structural reality in which newcomers are subjected to a process of being moulded into 'good' professionals (Clouder 2003). One such theory around socialisation was developed by Merton et al. (1957) from their work with medical students, in which students were seen as empty vessels and passive recipients, ever ready to be filled with the teaching and experience offered to them. This implies that the individual's experience is within the context of the institutional body that nurtures them and maintains the profession's knowledge and culture. Olesen and Whittaker (1968) describe the result of this process to be '*the true professional*', '*the finished product*', '*the outcome of the system*' (p5). Participants in my study concurred with this and believed this occurred both within the educational and practice settings. For example, mentors mentioned

how junior doctors had already learnt how to behave towards and react to other professional groups before entering clinical areas. This was perceived negatively by some nurses, who mentioned arrogance and aloofness as being characteristics of junior doctors. They believed these attitudes and behaviours were learnt during training from fellow medical staff (e.g. lecturers and senior medical staff).

The educational environment has traditionally been segregated, with uni-professional education and input; i.e. doctors teaching doctors and nurses teaching nurses. Although this has changed in recent years with more experimentation by means of shared learning sessions and interprofessional workshops (O'Halloran et al. 2006, Freeth 2001, Freeman et al. 2000, Parsell et al. 1998), the number of these sessions have been limited and as yet have not been extensively evaluated (Barr et al. 2000). In addition medical education has historically been dominated by didatic teaching methods.

Becker et al. (1968) moved away from this functionalist methodology and adopted an interactionalist approach, in which it is believed that the student will negotiate their role and determine their actions based on their reaction to and experience of the educational process they receive. Other studies have also suggested that trainees develop a role for themselves and learn how to be in relation to their surroundings (Bucher and Stelling 1977, Shuval 1975). An example from my study demonstrated this, in that individuals who had undertaken the same training held differing views about their role or their relationship with other professionals, and were perceived differently by the nursing staff. However, it could be argued that trainees do not really have control over the roles they develop because they have to base that role on what they feel their profession expects of them. They then play the role that provides them with the key to enter the profession and be accepted (Clouder 2003, Becker et al. 1968). It is therefore not a role that they truly want for themselves but one they adopt to survive.

Participants in my study also mentioned how they learnt what to do in different situations, such as who to approach for help, who to avoid, what they could do on different wards or what they could expect from different individuals and professionals. An observational study of medical students by Shuval (1975) also found that students responded to the cues they received

about being a professional and subsequently played that role in order to belong and be accepted. A criticism of Shuval's study is that only observational methods were used and no details were given about how the researchers determined which actions were attributed to the socialisation process of the individual. Subjectivity was also a major issue in that there was no mention of any mechanisms for ensuring that what they observed was true to the experiences of the medical students, e.g. comparison of field notes of several observers or sharing of field notes with those being observed. Another method would be for interviews to be conducted with some of the students to provide meaning to what was observed. Another issue with this study was the Israeli setting used which may not be appropriate to the culture in the United Kingdom (UK). The Israeli educational system is embedded in a strong tradition of authoritarianism that can create in the individual an attitude of being told what to do rather than developing a sense of independent investigation for knowledge. This goes against the ethos being developed in the UK in relation to life-long learning and continuing professional development, which advocates an individual responsibility for education and development.

Dingwall (1977) expressed the same process for socialisation but linked it with competency. He describes socialisation as:

> *A process by which newcomers to a group work to make sense of their surroundings and come to acquire the kinds of knowledge which enable them to produce conduct which allows established members of that group to recognise them as competent* (cited in Howkins and Ewens 1999, p42).

This is applicable both to entering a professional group or a work environment. This relates to my study in that PRHOs expressed anxiety about their registration and about being deemed competent and accepted into the profession; hence some junior doctors' decision not to disclose their fears or inability to carry out certain clinical skills for their educational supervisors. They found other mechanisms to allay their fears, e.g., asked nurses or their peers about clinical situations, in order to appear confident in front of their senior medical team. This can be stressful, as mentioned by participants in my study, and as Shuval (1975) concluded it can be confusing for the individual trainee or newcomer who plays many roles.

Kramer (1974) suggested setting goals for the purpose of socialisation. It could be argued that such goals are set by deaneries but they pertain mainly to clinical skills rather than other aspects of socialisation, such as interactions with fellow workers. However, I believe that a great deal of socialisation occurs unconsciously whereby junior staff automatically observe and repeat the actions of senior staff. For some actions, there is no value judgements made initially and, as a natural survival instinct, actions are learnt. It is only as junior staff gain confidence that they start questioning their own practice and that of others. The junior doctors in this study reinforced this by mentioning how initially they did what they had to in order to get the work done, but that this changed to more purposeful action later as they gained confidence.

Socialisation into an occupational role is chief amongst the socialisation processes in adulthood according to Kramer (1974), who suggests that socialisation is '*the process by which one learns to perform his various roles adequately*' and '*is continuous throughout life*' (p137). It is ultimately a profession that students and junior staff are entering, and this socialisation and learning involves the practical element of the job and equally involves learning the values and beliefs of the profession, which could be described as the profession's culture. Participants in this study mentioned the concept of professional culture repeatedly and explained how each profession had, over the years, developed its own practices and policies to form its culture, which ultimately impacted on its members and their relationship with other professions.

Holland and Hogg (2001) believe that different cultures establish values and norms that affect how individuals communicate and behave towards each other and towards other professions. Comments from participants in my study concurred with this view of culture, with both nurses and doctors identifying patterns of working within their own profession that they had to learn, as well as patterns of practice and behaviour that were observed among members of the other profession. Hence socialisation into a profession involves learning about its culture and adopting the values and behaviours of that culture. Examples of this were given by interviewees where activities such as nursing 'hand over' or doctors' 'ward rounds' were considered part of the culture of each profession. These cultures were learnt from senior staff and passed from

one generation to the next. Again this was attributed to role modelling and observation of others, where values and characteristics of the professional culture were discovered and internalised.

Participants also mentioned how the professional culture shapes and determines the roles and responsibilities of each professional group. Holland and Hogg (2001) believe that an individual's culture determines the pattern in which they undertake their roles and responsibilities in all aspects of life. For example, a number of PRHOs commented on the way nursing team's practice, whereby certain tasks are carried out at different times of the day or only by certain grades of nurse. Another example was participants' understanding of professional roles, with nurses being mainly involved in the caring aspect of patient care and doctors responsible for prescribing care. The literature also highlights this issue of differences between the two professional cultures. Snelgrove and Hughes (2000) studied the interprofessional relationships between doctors and nurses using semi-structured interviews and found that practitioners' account of their roles reflected the traditional model where doctors diagnose and prescribe, while nurses are concerned with the social and emotional care and monitoring of treatment. They found that nurses were excluded from decision-making processes for patients. Melia's (1987) study also found this care versus cure debate and further discovered a power issue in that the medical aspects of patient care were deemed more important by student nurses, which could be a result of the student nurses' lack of confidence in their own practice.

Although these studies have resonance with my study, in the case of Snelgrove and Hughes (2000), there is no information about the age range of the participants or their training background. It could be argued that practitioners who received their training a number of years ago when such divisions of roles and responsibilities were more prominent will have differing views than newer practitioners (Greenhalgh 1999). Participants in my study observed this difference in attitude regarding roles and responsibilities among different age groups in health care, i.e. longer practicing staff were less keen on interprofessional working or collaboration. This has implications because, if junior staff enter an environment that favours a non-collaborative approach to patient care, they will learn attitudes, values, behaviours and practices that go

against the requirements of team working. Some attitudes would include lack of respect for the contributions made by other professional groups to health care and a lack of collective consensus on the health needs of patients.

It was clear both from this study and from the literature, that the roles and responsibilities of nursing and medical staff, as well as their relationships, are changing (Tabak and Koprak 2007, DoH 2000c). A health service that requires a more collaborative method of healthcare delivery will need to examine the working culture among its members. According to participants, this means developing a new culture that embraces all professional groups. I believe that interprofessional mentoring can contribute to this new culture of nursing and medicine. Many participants acknowledged that interprofessional mentoring went against the normal practices of both professions. The role of a mentor in relation to their own profession was clear to the extent that experience and literature allowed, but mentoring someone from another profession was not always clear to participants. However, through support and reflection on practice, interprofessional mentoring provided a way for the two professional groups to explore their respective roles and find the similarities and differences in their contribution to patient care. This study presented an opportunity for closer dialogue and working experiences between the two professional groups, contributing to understanding, respect and collaboration, identified by the participants as the important ingredients of this new culture.

In their mixed method study of doctors and nurses, Prescott and Bowden (1985) found that the amount and longevity of contact between doctors and nurses helped their working relationships. Although the focus of their study was on disagreements between nurses and doctors, their findings contribute significantly to understanding of relationships and patterns of conflict resolution, which can affect collaborative working. Thereby, interprofessional mentoring which also provides increased contact and interaction between the two professional groups can be seen as a mechanism to foster the creation of a culture of collaboration.

According to participants, the clinical setting provided junior doctors with immense learning opportunities, particularly in relation to interactions with other professionals. Mann (2002) advocates that knowledge is constructed in the environment and is situated there, i.e. 'situated learning', which is a social

process that occurs in interactions with others in the same environment through listening or talking about the framing of and solutions to practice. This was the case in my study when participants expressed how they were able to talk to different professionals and different grades of professionals, gaining knowledge or skills as a result of that interaction. Structured interprofessional mentoring ensured that PRHOs had at least one contact with someone from the nursing profession with the purpose of learning about that profession, particularly if the junior doctor did not have the social skills required to converse with others.

Both mentors and mentees acknowledged that the best way for junior staff to learn was in practice, where they could observe and be observed. Role modelling was a major contributor to socialisation and learning for newcomers, according to participants. Olesen and Whittacker (1968) state that the process of socialisation is about 'becoming', but that it is influenced by the judgement of the trainee and the environment in which they are learning. The nurses and doctors in my study mentioned how junior staff emulated senior staff and so picked up the practices, ideas and attitudes exemplified by their seniors. They gave value to the personal and professional actions of the senior staff and judged whether learning to copy the action would help them in their practice. This was also in relation to all aspects of functioning as a professional within an organisation, such as developing clinical skills, interpersonal relationships, communication and attitudes towards other professions. Bucher and Stelling (1977) suggested that role modelling is more complex than generally accepted, and identified five models which had application for trainees in their study. Most of these correlate with the findings from my study and are demonstrated in Table 13:

Interprofessional mentoring	**Understanding the findings**

Bucher and Stelling's five common models
Findings from my study about role modelling
Partial model – involved trainees selecting particular characteristics or traits that they admired and wanted to emulate. Specific attributes were sought from different people rather than having just one global role model; thereby, it was about copying traits rather than individuals.
Most junior doctors commented on how they learnt different things from different people they came across during practice. They particularly mentioned registrars, consultants and senior nurses whose practice they tried to incorporate into their own, i.e. learnt from their example.
Charismatic model – highly idealised global models that inspired tremendous enthusiasm and awe in the trainees. Trainees wanted to be like these models but were aware they could not achieve the same level. Therefore they always spoke very highly of the role model.
While thinking of role models, both nurses and doctors remembered individuals whom they had met during their time in practice that they perceived to be excellent practitioners. They mentioned some of their actions and how they had not come across others who practised in the same way.
Stage model – these models gave trainees information and advice about the different stages of development. They were mainly senior peers or junior staff members who had practical experience.
Senior house officers specifically fell into this category and were mentioned repeatedly by PRHOs. They were seen as individuals who were on the same journey as themselves, but one step ahead and therefore able to warn them about what was to come.
Option model – these models were used to glean information on alternative or deviant career patterns.
Nothing like this was identified in my study
Negative model – besides the charismatic model, all others can be positive or negative models.
Junior doctors mentioned how they encountered senior practitioners whose practice they questioned and did not approve of. Mentors also commented on the negative aspects of role modelling that impacted on the practice and the behaviour and attitude of junior staff.

Table 13. Correlation between findings from my study and Bucher and Stelling's (1977) study

In Bucher and Stelling's study, all participants had senior medical staff as their role models, unlike my study, which called for junior doctors to have close collaboration with nursing staff and engage in a learning process with them. However, I believe that Bucher and Stelling's models apply just as appropriately to the relationship between the mentors and mentees in my study, i.e. nurses can be role models whose practices PRHOs would like to emulate;

nurses could equally have a negative effect on the attitude of junior doctors by their actions or practices.

It is clear from the findings that role models can have either a negative or positive effect on junior staff, which ultimately impacts on their learning and socialisation. My findings also illustrated that no one role model was adequate to shape the learning and development of junior staff and that different individuals influenced and impacted on the socialisation of junior staff, e.g. peers or senior staff from various professional groups. Shuval's (1975) observational study found that different hospital personnel and patients had an active role in the process of learning for junior doctors and shaped their views and attitudes both positively and negatively. Examples of this were given by a few mentees who mentioned past interactions with nurses that had caused them to conclude that nurses lacked confidence, shrugged responsibility and generally made work difficult for doctors. Therefore, they had a negative view of nurses and about the possibility of collaborative working, and could not understand what they would gain from having a nurse mentor. On the other hand, some junior doctors mentioned how they had learnt skills, such as communication with patients, by observing nurses whom they believed had better all-round communication skills.

Most participants acknowledged that nurse mentors were and could be instrumental in the socialisation process of junior doctors, but there was no unanimous agreement as to how this occurred. Just having a mentor or being with a senior staff member did not guarantee learning. Mentors needed to have certain qualities, and had to cater for the specific needs of their mentee. For example, some mentees believed that nurses could teach them certain clinical skills but that specific medical aspects of their work, such as medical management of patients, could only be learnt from or exemplified by senior doctors. Other PRHOs commented that senior nurses had, through years of practice, become fully acquainted with the medical management of patients and could support mentees in this aspect of their development. Mentors were also divided in their views about how they could help the development of junior doctors. Since there is no consensus on the definitions of the terms 'interprofessional' and 'mentoring', the parameters of 'interprofessional mentoring' are unclear. It can therefore be adapted to meet the needs of the

individuals and the organisation. My study has given some strong indicators of the issues valued by participants which it is hoped, will guide future provision of support.

In relation to socialisation into a profession, Bucher and Stelling (1977) assert that until a person is actually working in his/her field of practice, it would be difficult to demonstrate if he/she has acquired the necessary skills and knowledge, not only to others but to himself/herself. Therefore, for junior staff to form their identity through this journey of becoming a practitioner, they need the experience of the clinical area. Kramer (1974) suggests that the practice setting for new staff becomes their socialisation community, and the community has a vested interest in influencing the behaviour and values of the new practitioner as they begin the process of role transformation and identity development. Many mentors commented on how, over the years, they had observed junior doctors taking on the traits and behaviours of the senior members of their team. This, they believed, occurred as a result of day-to-day working with their seniors. A few mentors described tension and uneasiness on the wards between the nursing and medical teams when certain senior staff were present in the clinical area. This, for some junior staff, became the norm and their actions and behaviour subsequently reflected the same approach demonstrated by the senior staff. Hudson's (2002) review of the literature highlights that novices are socialised into a profession in such a way that they assume an identity similar to that of their mentors, thus perpetuating the profession as it is. He continues that much of this type of learning is informal with no constituted theory but is seen as 'practice wisdom' of the profession by directly addressing the day-to-day realities of being a practitioner. Mentors concluded that, to ensure future practitioners are able and willing to work more collaboratively together, the example has to be set by existing senior staff in the working environment. They believed that senior staff had the responsibility to create a collaborative environment so that junior staff could learn from their example.

Wenger (1998) draws a parallel between identity and practice, stating that identity is rich and complex because it is formed within a rich and complex set of relationships in practice; hence the identity of a newcomer would, to an extent, reflect the identity of the environment. Bucher and Stelling (1977),

however, believed that, although role models did influence identity, trainees were selective in adopting the ideal model appropriate to them. My study suggested that by having working models, such as interprofessional mentoring, incorporating the benefits of collaboration, junior staff will have access to an alternative model in practice, to adopt in preference to a uni-professional approach. Bucher and Stelling's participants differed to those in this study as they were further along their career path to the point of training in their chosen speciality. They had, to a greater extent, formed their identity in relation to their profession and were mastering their skills in a specific speciality, which can be classed as a subculture of the general culture of medicine. However, their socialisation and identity building was similar to that of participants in my study, even though they were at different stages in their journey of becoming a professional. Both sets of participants were learning to function in a new environment, one starting in the health care system and the other in a new speciality.

There were many facets to the contribution that interprofessional mentoring made to this journey of socialisation into practice. The changes within health care recently have been manifold, particularly in relation to role and identity changes for those working within it, with a strong emphasis on integration of services and interprofessional working (DOH 2000a, 2000b). In the first instance, interprofessional mentoring allowed the two professions to have a better understanding of each other's roles and responsibilities and their respective contributions to patient care. Second, it provided an environment in which the junior doctors had easy access to nursing staff through the mentor, giving them another role model in relation to patient care. Third, the very nature of interprofessional mentoring meant that doctors and nurses had a more meaningful and reflective dialogue together through regular meetings, examining the work of the junior doctors and realising their learning needs, which otherwise may not have been available to them. These experiences can ultimately shape the development of the mentee's identity and change the usual pattern of socialisation that would normally have occurred in a uni-professional approach. Stark et al. (2002) suggest that, in the current structure of the health service, it is difficult to promote collaboration, and ideas such as team working need to be caught rather than taught – the best way of doing this is through

hands-on experience. Interprofessional mentoring is one such experience for junior staff to learn how two professional groups can work together and help and support each other, both personally and professionally.

In summary the substantial learning experience during the early days of practice is acknowledged. Becoming a practitioner involves more than just learning certain knowledge and skills; it involves socialisation into the profession and the working environment. Through this socialisation, a process that commences at the start of training and continues throughout the various stages of one's professional development, the practitioners develop their identity as competent professionals. Socialisation is mediated by learning from role models and observation of other peoples' practice, and is governed by the prevalent culture of the profession and the practice environment.

A health service that requires a more collaborative method of health care delivery, must develop a new culture that embraces all professional groups. It is felt that interprofessional mentoring schemes, could be an effective strategy in fostering the development of this new culture.

5.2.2 Interprofessional mentoring as a means for collaboration to aid practice and to become a professional

Participants acknowledged the call and need for interprofessional, collaborative working to provide an efficient service for the benefit of patients. This section looks at the meaning attributed to collaboration, including the benefits and challenges it brings to the working environment, and explores how interprofessional mentoring promotes collaboration. While describing what collaborative working entailed and what their perceptions and experiences of interprofessional mentoring were, it became clear that participants in this study saw them as part of the same process. For example, collaboration they believed needed effective communication, and collaboration, in turn, was a mechanism for improving communication. This they believed was the same for interprofessional mentoring, which aimed to foster effective communication and at the same time it required the mentors to be effective communicators. So, in this section, I concentrate on the perceptions of interprofessional mentoring as part of collaborative and interprofessional working, and also examine the importance of communication.

There were clear indications from the findings that becoming a professional meant being able to work not only with patients and members of one's own profession but also with a variety of different professional groups. Collaboration was seen as a means of achieving this working relationship and was a word that was repeatedly used by the participants to describe interprofessional and team working. Interprofessional working they associated with the need to collaborate. Interviewees believed closer collaboration among staff resulted in improved patient care and an enhanced and healthier working environment. Collaboration could be aided by early interaction among healthcare staff, according to participants, possibly as early as during training. For collaboration to occur there was a requirement for understanding the contribution to patient care of each professional group, as well as the respect and acceptance of that contribution. This raises many issues about the history of the two professional groups and the power struggle between them. A common goal, willingness to work together and effective communication (which is discussed later in the chapter) were identified as crucial factors in promoting and assisting collaboration.

This section on collaboration is divided under the five headings, all in relation to and from the experiences of interprofessional mentoring. This section will look at the aims of collaboration, requirements for and defining attributes of collaboration, challenges of collaboration, communication and its influence on collaboration and practice, and finally, results and consequences of collaboration.

Aims of collaboration

Words such as integrative, interprofessional, multiprofessional and team working were all associated with collaboration by the participants. These words were used interchangeably and given similar meaning. In this study collaboration is used as an umbrella term incorporating team working, interprofessional working and multiprofessional working. This reflects the same confusion and uncertainty evident in the literature around the issue of integration and collaboration in health and social care (Elston and Holloway 2001, Miller et al. 2001, Barr 2000). Since one of the aims of interprofessional mentoring was for nurses and doctors to have a closer professional relationship

and to help with the understanding of each other's roles and responsibilities, it could be argued that through this experience participants were better able to work interprofessionally and within a team. However these terms are defined, it is clear that a major requirement of collaboration is an understanding of the roles and contributions of all professional groups involved; interprofessional mentoring would therefore prepare practitioners for that process. Mentors and mentees both described collaboration as a means of enhancing patient care by providing continuity and high quality care through improved communication and better relationships between healthcare professionals. Participants believed that for collaboration to occur there had to be a common goal, which they agreed was the care of the users of the services they provided. Henneman et al. (1995) also concluded that collaboration is frequently equated with a bond, union or partnership, characterised by mutual goals and commitment. However, it is imperative that the common goal is unanimously agreed upon by all practitioners.

Participants agreed that in recent years the driving force within the NHS has been to achieve a more integrated care system through collaboration, with the hope of improving the delivery of services. Interviewees acknowledged that the emphasis on collaborative working had increased significantly and had to be addressed by both professionals and organisations. Although there has always been a need for healthcare professionals to interact with each other within the NHS, the level of interaction has been varied and a matter of debate. Since the new NHS Plan came into being in 1997, the drive towards a more integrated service has been at the forefront of subsequent papers, policies and recommendations by the Government and its agencies. According to the British Prime Minister, Tony Blair, the aim of the new NHS is a partnership and performance-driven service that provides equitable, efficient and integrated care (DOH 2000a). The new NHS Plan should be about providing a more seamless service, where organisational agendas and barriers do not create a fragmented service and an improved holistic service is offered through new working relationships between health, educational, social and housing services.

Participants in my study were in favour of improving the health service through a more collaborative approach amongst the various health and social care professionals and agencies, but difficulties arose from the lack of clarity

and consensus about the meaning of collaboration. For example, the level and nature of collaboration was different amongst the interviewees. A few saw collaboration as each professional group working in teams together and then sharing the information with other professional groups, while others saw collaboration as the formation of teams with members from all professional groups who would meet regularly to review patients. Elston and Holloway (2001), in their study with health professionals in primary care groups (PCGs), also found differences in the interpretation of the term 'interprofessional working', with the doctors focusing more on their practice in relation to others, while nurses emphasised the relationship between all the professions in the PCG. Although their study was in a primary care setting, the attitudes of the doctors were similar to those in my study where some of the PRHOs associated the word 'team' with their medical firm and saw other professionals (whose contribution they valued) supporting the decisions they made.

Even though perceptions of what collaboration meant varied, it was unanimously agreed that collaboration would improve patient care and benefit staff. Participants believed that, through collaboration, healthcare staff would have more job satisfaction as a result of effective communication, understanding, trust and respect, which would improve the working environment. Participants also agreed that interprofessional mentoring aided collaboration by providing the opportunity for dialogue between the professional groups in a supportive environment. This enhanced the understanding of roles and responsibilities, which is vital if different professionals are to work together. Gerard's (2002) review of literature on the challenges and opportunities of interprofessional collaboration also demonstrated the importance of mutual respect and appreciation of the contribution of each profession to enhance collaborative working. There is also positive correlation between high job satisfaction and good multi-disciplinary team working (Young 1994).

Requirements for, and defining attributes of, collaboration

The major requirement that was repeatedly mentioned by participants was the need for understanding of the roles and responsibilities of other professional groups alongside valuing of the contribution of their knowledge and expertise

to patient care. Participants in my study expressed how they had minimal knowledge of the training programmes of the other professional groups, which led to junior nurses and doctors not knowing what the other was able to do in practice. Senior nurses, however, had come to learn through experience and closer working relationships what to expect from junior doctors. This was not the case for senior doctors who had less interaction with junior nurses. It became clear that the more interaction that occurred between the professional groups, the better the understanding of roles, leading to a greater ability to work more efficiently together.

In a study of relationships between nurses and general practitioners in rural Australia, Blue and Fitzgerald (2002) found that good working relationships between the two professional groups were due to the higher social interaction as a result of the small community in which they worked. Their physical proximity appeared to promote understanding of the contributions of others and foster the development of relationships. This was a difficulty for the participants in my study in relation to mentoring because most of the mentees worked across many wards and were not in the same place as the mentor for a sufficient length of time to build a relationship together. However, the formality of the project meant they had to make time to see each other, thereby ensuring that the connection was made between them.

Leaviss's (2000) study of the perceived effect of a multiprofessional course on the work practice of newly-qualified healthcare professionals showed that the course increased the participants' knowledge of the other professions and that this effect had persisted beyond the duration of the course. She concludes that sustained and prolonged contact with other professions will change individuals' views about those professional groups. Although her findings were positive and correlated with my study about the need for more interaction, I would question whether a two-day course could have the level of impact that was reported. However, her study does demonstrate that interprofessional learning at undergraduate level was perceived as beneficial by those who participated. The contribution that interprofessional mentoring made was to provide this additional close interaction between nursing and medical staff which Leaviss advocates is something that has not happened in the past. As a

result, a clearer understanding of the abilities and expertise of each professional group was observed by both mentors and mentees in this study.

Participants highlighted that understanding roles and responsibilities was just the first step in supporting collaborative working. Understanding how each professional contributes to the delivery of care was also important. In addition, valuing and respecting that contribution was seen as imperative (Gerard 2002). A few mentors and mentees gave examples of how the work of their profession was not respected and that they were not given the opportunity to take part in decision-making processes. This was particularly the case with nurses who mentioned that the attitude of the medical profession was one of arrogance and exclusivity. Mentees, on the other hand, expressed the need for nurses to take on more responsibility and so earn respect for their part in patient care. The nurse–doctor relationship has been an ongoing debate historically and will be discussed further under the challenges to collaborative working.

Many of the interviewees believed that if collaboration and interprofessional working were to become part of the practice of healthcare staff and providers, it was necessary to begin the process of integrating health professionals early on. Many expressed the need for more shared training and believed that much of the core knowledge and skills, particularly of nurses and doctors, were similar and could be taught together. Some mentioned that joint training did not just mean different professionals sitting in the same classroom together but rather required opportunities of shared dialogue in order to understand how the different professions could complement each other's work. The Bristol Royal Infirmary Inquiry (2001) also concluded that more shared learning opportunities need to be provided for health care students, so that on entering the workforce they are able to work collaboratively together. Most acknowledged that no one profession could provide all the care required for patients and that they relied on other professionals to complete the care provision. These issues have also been highlighted in the literature. In recent years, increasing emphasis has been placed on finding ways of making service provision more efficient and effective, and the conclusion appears to be the need for more effective collaboration (DoH 2000c, 1997) because the complexity of patients' needs necessitates the involvement of more than one professional group. The challenge to interprofessional collaboration has never

been the understanding of the need for better working relationship between healthcare professionals but rather what constitutes this collaboration and how it is best achieved.

Whether or not early interaction aids the process of collaboration was not clear from the findings of this study. Participants were divided in their opinions for two reasons. The first was PRHOs' personal experiences of working with student or staff nurses during their training. A study by Nadolski et al. (2006) explored third year medical students' perceptions about their interactions in clinical settings with nurses and other heathcare team members. Findings from their survey suggest that the interaction between the medical students and the practicing nurses were suboptimal and did not provide sufficient opportunities to establish high levels of mutual understanding and collaboration. In conclusion they suggest that medical students are not receiving the sorts of educational experiences to advance doctor-nurse collaboration. Second was the view of both professions that they had distinct educational needs in order to function as practitioners. The literature is also divided in respect to the benefits of early integration of the two professions and its impact on professional identity. Some assume that interprofessional or multiprofessional education and interaction from the early days of training will influence attitudes positively towards future team working and diminish the risk of students becoming too fixed in a conventional professional role (Nadolski et al. 2006, Hall and Weaver 2001). However, others disagree: unless individuals are confident in their own profession and develop a strong sense of professional identity, they will not be able to input into a team as they will not have an understanding about the contribution of their profession or the skills and knowledge they bring to patient care (Mariano 1999, Soothill et al. 1995).

Participants in my study had varied experiences and perceptions of early interprofessional encounters. Some PRHOs had received joint lectures with other healthcare professionals and were indifferent about attending these lectures. Others had been involved in small projects with other healthcare professionals and found it useful to mix with them. However, in their opinion, they had not necessarily learnt anything valuable. A whole cohort had worked for a couple of days with nurses in practice. Some had found the experience beneficial in understanding the way nurses work, while others developed a

negative attitude towards nursing staff due to the way they had been treated by the nurses in practice. This demonstrates the complexity of interprofessional education and working which is influenced by many factors. All the examples given were one-off, short-term encounters with little preparation. Freeth (2001) suggests that short-lived, short-term funding and unrealistic expectations have been the cause of negative views about interprofessional working and learning. She elucidates that time is required to nurture interprofessional collaboration, particularly when no culture of collaboration exists and, as in the case of nurses and doctors, there has been a tradition of enmity. It is no wonder that a few workshops or a day's encounter would not yield great positive effects. Interprofessional mentoring, which for PRHOs should last for the duration of their pre-registration year, provides a significant period of time of interaction to allow for both the development of personal relationships and adequate exposure for the nurturing of that relationship. Ideally it would be beneficial for junior staff to participate in interprofessional education during their training thereby allowing interprofessional mentoring to build on that experience.

Two other issues that became apparent while PRHOs shared their stories of interprofessional encounters were the attitude of those involved and their environment. The commitment of individuals to collaborate together is a requirement for successful collaborative ventures. Most participants in my study agreed that commitment and enthusiasm are required if interprofessional initiatives are to be successful. This was exemplified by the outcomes of interprofessional mentoring. Those participants who were positive and enthusiastic about mentoring generally reported good experiences and had some level of interaction with their mentor or mentee. Lathlean and May's (2002) action research projects, exploring a multiprofessional 'communities of practice' approach to collaborative interagency working, also found enthusiasm and commitment to be the two major and important factors for success. They suggest that commitment is related to the desired goals and enthusiasm is likely to be linked with the actual potential to make changes to services or practice. Although their study focused on the concept of communities of practice as developed by Wenger (1998) and was based in primary care and outpatient settings, which are generally viewed as areas that are more conducive to collaborative working, many of their findings did correlate with my study.

Being in an environment that promotes interprofessional working, where collaboration can 'be caught rather than taught', was seen to be essential according to participants in my study who also mentioned that interprofessional education would not be beneficial if the practice environment was not conducive to collaboration. This would be the same as the theory–practice gap that has plagued the education of healthcare professionals, where students are taught the ideal way to deliver care but find something else in practice. The practice setting has to reinforce the knowledge base rather than add confusion and uncertainty for junior staff.

While conducting this study, it became clear that in becoming a practitioner there were many learning processes that occurred simultaneously for the junior staff. I believe that much of the learning of healthcare professionals happens according to Bandura's (1977) social learning theory, where human behaviour is explained in terms of a continuous reciprocal interaction between cognitive, behavioural and environmental factors. Both people and their environment influence each other reciprocally. Hence, if PRHOs experience interprofessional education, are informed of the importance of collaborative working and are provided with the theory, there is a need for that cognitive knowledge to be supported by the environmental determinant. When this does not happen, there is a discrepancy between what they know cognitively and what they experience. However, not everyone develops a negative view or behaviour due to this discrepancy, which means there are other factors involved. First, students do not always come into training as blank entities. Rather they have other life experiences that also impact on their socialisation into the profession and organisation (Freeth and Reeves 2004). For example, one PRHO who was very positive about collaboration had worked as a healthcare assistant before starting medical training and so had first hand experience of what being a nurse involved and was more sympathetic about the stresses experienced by nurses. Second, as mentioned before, students and junior staff are not passive recipients but are reactive to experiences. Jarvis et al. (2003) refers to Kolb's learning cycle (an experiential learning cycle) where experiences are observed and reflected upon to allow the formation of new ideas or concepts that are then put into practice, experienced and reflected upon again (see Figure 2).

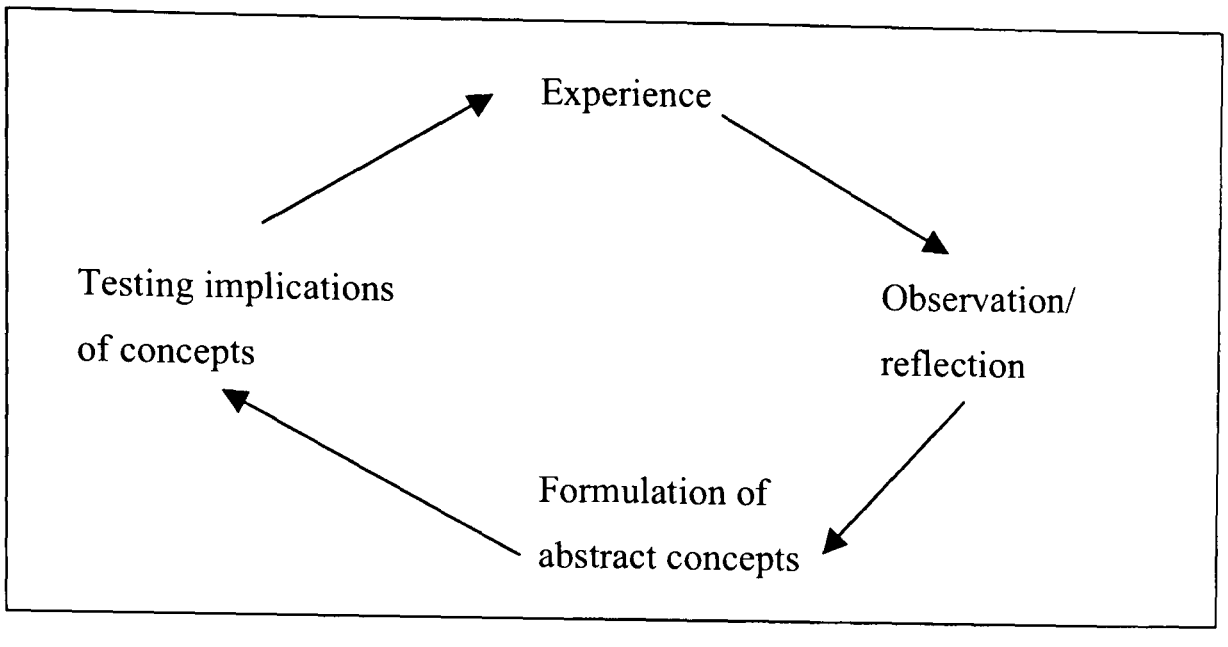


Figure 2. An experiential learning cycle (Jarvis et al. 2003, p58)

One female PRHO demonstrated how, even though she had received no interprofessional education and had not observed examples of collaborative working in her first post, through her past experiences and her observations of nursing staff she saw a dichotomy between what nursing staff did and how they were perceived by medical colleagues. Through reflection on this observation she was able to develop her own theory about working with nurses and her relationship with them.

I believe that learning about collaboration should start from early on in training through different encounters with other professional groups, with definite aims and outcomes that meet the needs of the individuals (Leaviss 2000), in environments that are conducive to interprofessional education and with individuals who are themselves advocates and promoters of collaboration. Also, interprofessional activities should not be one-off activities but should be systematically planned to build on each other (Leaviss 2000). I believe that interprofessional mentoring can be one step in that systematic experience of collaborative healthcare provision for professionals on their journey to becoming practitioners and experts.

Another major facet of interprofessional mentoring that became evident was the level of reflection that occurred during the meetings between the mentor and mentee. Reflective practice has become an integral part of nursing practice (Burton 2000) whereas in medicine it is starting to be explored as a learning tool (Kneebone 2002). Nurses have traditionally been doers but with

the drive toward evidence-based practice there is a need for a questioning mind (Driscoll 1994). Over the last 20 years, an increasing amount of literature has been written about the need to reflect in and on practice. From the findings in this study, the first few months for junior doctors is a time of just learning to do rather than reflecting on why it is being done. However, they too need to learn to reflect, particularly in relation to collaborative working where new ways of practice have to be judged for their benefits. The work of Schön (1983) has been instrumental in the progress of reflective thinking and working amongst nurses. His ideas of reflection-in-practice (thinking while doing) and reflection-on-practice (retrospective reflection) aim to achieve learning and change behaviour, perceptions and practices.

Mentors mentioned how they used a reflective approach to help support mentees and aid in their learning. They mainly helped PRHOs reflect on practice and to identify what they had to do to improve or change their practice or circumstances in their working environment. Learning to reflect together was an achievement in this project for some participants, which was seen to be a useful tool for aiding collaboration. Examples of effective collaborative working that incorporate a high level of interaction, joint decision-making and complementary provision of care are limited. Therefore, by using reflection in and on practice, practitioners will be able to ensure the outcomes of collaborative initiatives meet the anticipated outcomes i.e. efficient service and improved patient satisfaction. An example was given by a mentor from a joint mentoring sessions between a junior nurse and junior doctor where, through joint reflection, they were able to learn about each other's stresses and find ways to support each other's work in practice (see Appendix F). The way the mentor described this experience resembled the learning cycle devised by the Development Training Advisors Group (Driscoll 1994, p47; see Figure 3):

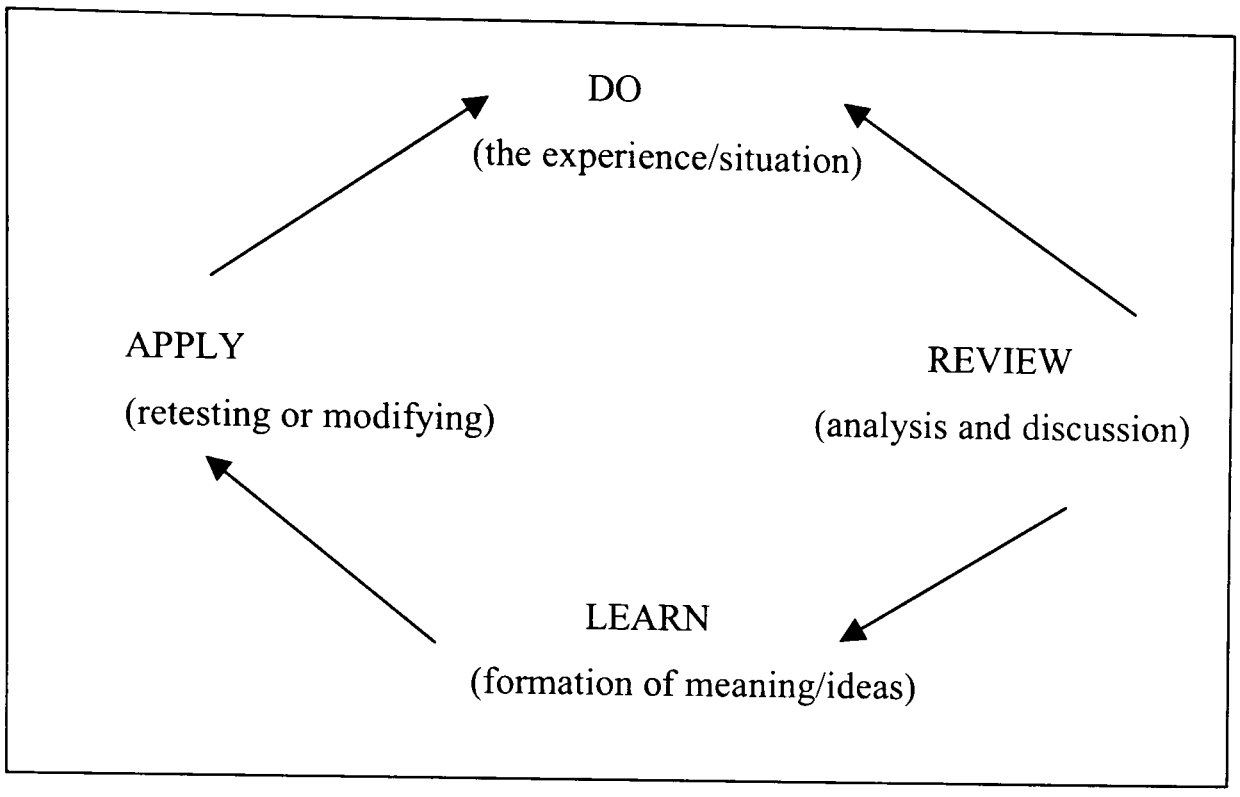


Figure 3. A learning cycle according to Driscoll 1994

This model may be helpful for interprofessional teams to reflect on the care provided for users but also on their functioning as a team. By using this process during interprofessional mentoring, junior staff can learn the skills of reflective practice in relation to both clinical skills and interactions with other professionals. Joint reflection is a subject that surfaced in this study but that requires extensive exploration.

Participants perceived mentoring positively as a tool for aiding collaboration at all levels of professional development. Mentoring should focus on different individual needs depending on the practitioner's training and experience. Lowe and O'Hara (2000), in their examination of multi-disciplinary teams (MDTs), suggest that professional development can occur in MDTs through the sharing of skills between professions, and advocate the use of clinical mentors to ensure continued development of professional skills. The difference between their study and mine was the setting. Primary care settings have historically been more prone to collaborative working than acute hospital settings and it could be argued that MDTs are more easily implemented in those settings than on acute hospital wards.

All the elements of collaborative working, such as understanding, trust, respect, communication, common goals, support and training, facilitate the

development of junior staff, in their journey of becoming a professional. This allows them to learn to function well in a team and be confident in their ability to contribute alongside other professional groups. Interprofessional mentoring aimed to promote an environment for this kind of learning to occur through interaction and joint reflection. The interaction between mentor and mentee provided prolonged exposure to the other professional group, helped understanding of roles, created trust and respect, enhanced communication skills and provided additional support and teaching opportunities for the development of the junior staff.

Challenges of collaboration

There were certain issues that impeded the progress of collaboration, according to participants, which were also factors that affected the impact of interprofessional mentoring. The main factors were: communication (which is discussed later) and the nurse–doctor relationship. The latter appears to be a multifaceted issue and includes the historical background of each profession, the power struggle between the two professions, and the development of values and stereotypical views of other professional groups. Practical or organisational issues such as patterns of working, workload, time and finances also created a challenge to interprofessional mentoring and collaboration. It appeared, however, that the power debate was the most influential contributor to the nurse–doctor relationship. Table 14 demonstrates how all issues that impede interprofessional collaboration arise from the historical power difference between doctors and nurses, which has shaped their relationships and views of each other as shown by my findings and the literature in this area.

Reasons for and contributors to the power struggle within medicine	**Impact of power on nurse–doctor relationship**	**Current changes in power influencing the nurse–doctor relationship**
Medicine has been functioning as a profession for much longer than nursing.	Over the years, medicine has established its expertise and knowledge. Nursing began to develop after medicine and appeared to come about as a means of aiding doctors in their work with patients.	Nursing has developed its own knowledge base and is identifying its contribution to patient care. Therefore, nurses no longer just depend on orders from doctors to be able to provide care.

Education and training is longer and more science based. Monopoly over knowledge as well as self-regulation giving power over society.	Medicine has had a long history of established education and training unlike nursing which originally was learnt in practice with no theoretical basis. Medicine therefore had the knowledge and the authority.	Nursing has developed its own knowledge base over the last 100 years, as well as its own professional structure. Nurses have found their own expertise to contribute to the experience of users. Nursing is now contributing to evidence-based practice.
Gender difference between nursing and medicine.	In the past, medicine was male dominated unlike nursing. This domination contributed to the power issue since it reflected the society at large. Nursing was associated with women's work, like housework, and was, therefore, not valued. Dominant–subservient model.	The gender ratio in both nursing and medicine has changed. In addition, the role and status of women has changed in society. This, in turn, has impacted on the way nursing is perceived by society and professionals. Partnership model.
Diagnose and take ultimate responsibility for patient care.	Doctors have always been responsible for diagnosis and nurses then carry out the treatment. Doctors take legal responsibility. Care–cure model (cure deemed more important).	Over the last 20 years, nurses have extended their roles with the introduction of nurse practitioners and consultants who have their own caseloads and can diagnose. Nurses are competing for equal power.
The issue of power and its outcomes have caused barriers between the two professions and contributed to the stereotypical views held by society towards nursing and medicine, and more importantly those held by professionals towards each other, which further fuels the barriers and impedes collaborative working.		

Table 14. Development of power and its outcomes

It was clear from the interviews that there were strong views, from both doctors and nurses, that they were professionals with different experiences and backgrounds. Both groups highlighted the expertise that they gained through their training and education as well as through experiences in practice and through the observation of senior colleagues. The notion of being a professional meant having certain skills, roles and responsibilities that they had

developed over the years of training and practice and were important for care provision. However, there were variations in opinion about how the two professions complemented each other or supported the work of the other.

The level of knowledge appeared to be a factor in distinguishing the two professions. Nurses and doctors talked about the knowledge and training of each profession to do certain tasks and acknowledged the differences in the length, content and level of training and education. It was clear that medicine was more theoretically based which to doctors was important whilst nurse training was more practice based. This was linked to the tasks that each had to perform. For example, a senior medical staff member mentioned how doctors diagnose and decide on what treatment is required and then nurses carry out the relevant procedures for the treatment. It was an accepted concept that doctors make the decisions and so have the responsibility for the patient, which places them in a position of dominance. Weiss's (1983) study also found that doctors were perceived as having a higher level of responsibility than nurses.

Comments particularly by doctors in this study exemplified this belief of having the monopoly over knowledge and power in decision-making. For example, one consultant affirmed how doctors had studied for five years to care for patients and '*not to empty bedpans*'. Clear distinctions were made by him between the different tasks carried out by the two professional groups based on knowledge, and how emptying a bedpan (primarily the nurse's job) did not require the level of studying that medical students have and was not as valuable as diagnosing the illness of the patient. This relates to the care–cure debate whereby doctors are more involved with the curing of patients whereas nurses and allied health professionals are responsible for the care and nurturing of patients (Baumann et al. 1998).

The medical model focuses on the biomedical or technological approaches (Webb 1996). Doctors are taught to apply a sequential model that first requires diagnosis and then the examination of possible treatments. Good 'cure' decisions are evident if there is good patient outcome and this is dependent on the doctor's level of knowledge and experience which generally carry high prestige (Baumann et al. 1998). Caring, on the other hand, is a concept that is less understood and remains poorly defined. According to Kyle (1995), caring is an elusive and imprecise concept; the outcomes of which are harder to

evaluate, unlike curing where the outcomes are more frequently and easily observed. Providing the care that involves patience, emotional support, education, empathy and closeness (Baumann et al. 1998) is necessary, but generally no quantifiable results are observed. The Caring Dimensions Inventory is a useful tool for measuring nurses' perception of caring (Watson and Lea 1997) but is unable to assess the views of service users, whereas positivistic approaches can easily demonstrate the benefits of cure e.g. randomised controlled trials for use of a medication for a certain condition. This has implications for collaboration if certain activities are not valued, as demonstrated by the consultant in this study who did not see emptying bedpans as being an integral part of holistic care and believed it to be of lesser value.

The taking of responsibility was also part of the power issue and relationship between the two professions. From the interviews it became clear that an area of contention was nurses' unwillingness to take responsibility. PRHOs commented that nurses were too quick to bleep them or refused to carry out certain tasks in order not to take responsibility for them. This they attributed to two things: first, the nurses' lack of knowledge and experience, and second, the view that nurses were only concerned with their work and were unwilling to support medical staff. A few nurses also acknowledged the unwillingness of some nursing staff to take responsibility but highlighted that it was easier for nurses to have their registration removed for minor deviations from their role. Examples of incidences were shared by nurses where doctors did not support nurses when they had given verbal instructions and there were subsequent complications with the care. Doctors also mentioned that there were nurses who were very capable and ready to take responsibility. They gave examples of some nurses taking the initiative before the doctor arrived, or were able to give a full accurate history about the condition of the patient so that doctors could make a judgement about how urgent it was to see the patient.

Prescott and Bowden (1985) also found similar views in their interviews with doctors and nurses. Doctors in their study mentioned how nurses' knowledge and judgement was not always sufficient for adequately assessing patients, which meant inappropriate phone calls for minor problems or the omission of significant changes. PRHOs in my study mentioned that over time they became aware of which nurses were more capable and which ones they

could not depend on. It became evident that time and opportunities to work together helped with the understanding of roles and competencies, and enhanced the nurse–doctor relationship. Prescott and Bowden (1985) studied nurses and doctors in America and found that the familiarity of doctors and nurses in terms of amount and longevity of contact was an important contributing factor for a positive relationship. They found that generally, once doctors had spent time with nurses, they were able to judge their level of competence. An interesting point made by the participants in their study was that nurses' knowledge and judgement were deemed suspect until proven otherwise by experience. However, nurses seemed to assume doctors' were competent unless proven otherwise except for new house officers who had to prove themselves trustworthy.

Patterns of working were a practical difficulty for interprofessional mentoring as is also the case with collaborative working. In a study of 152 community rehabilitation teams in the UK, Enderby (2002) found that, due to shift patterns and full- or part- time working, it became challenging for team members to meet. She suggests that time to get to know each other personally and professionally is important and that it would be necessary to establish and maintain team cohesiveness on an on-going basis as membership changes and evolves over time. Working at the same time and in the same place allows for relationships to be developed which in turn helps the working environment.

In my study, difficulties identified were the lack of opportunity for PRHOs and mentors to work together or have meetings due to their working patterns. Participants also acknowledged this as a problem for collaborative working. This was for two reasons. First, working patterns did not allow them to get to know each other well or quickly enough, and second, in the case of PRHOs, participants felt that by the time they got to know the doctors and found a pattern of working with them they would move on and new medical staff would start. A few nurses mentioned that the consultants in some cases maintained the continuity as they were constantly there, whereas PRHOs, SHOs and registrars were only in the medical team between three to twelve months. However, as mentioned earlier, even in this short period that PRHOs are attached to a particular team, the role modelling of senior staff can have a significant influence on the socialisation and behaviour of junior staff. An

example given by nurses was the difference in attitudes of medical staff depending on the consultant team to which they belonged. Therefore, a consultant who practiced in a collaborative way with the nursing staff always appeared to have medical staff who were able to work well with nursing staff, even if they had only been in that environment for a short time. This was also true of senior nurses and their influence on junior nurses.

Communication and its influence on collaboration and practice

Communication is fundamental to nursing practice and, once considered a minor subject, is now ranked as a core clinical skill within medicine (GMC 2006 and 2005, Silverman et al. 1998). Communication was a major contributor to effective collaboration, according to participants. They believed communication to be at the core of the health service and that without efficient and successful communication, both patient care and the functioning of the organisation would be adversely affected. The ability to communicate impacted positively on the working environment. However, there was again a discrepancy about the nature and level of communication needed to make the system function, and to aid and improve patient care, experience and outcome. Factors identified as impeding communication were lack of time, workload, poor communication skills and negative attitudes towards other professional groups. These factors are similar to the barriers identified in interprofessional working. This section explores the above factors in relation to communication.

Communication is now recognised as a major aspect of healthcare delivery (Rungapadiachy 1999) and is generally viewed as an area that requires more exploration (Suzuki Laidlow et al. 2002). In this study communication amongst healthcare professionals was a key focus and most participants mentioned difficulties of communication at varying levels. Reference was also made to the deficiencies in communication with patients as is also highlighted in the literature. Bowles et al. (2001) refer to the early work of Menzies (1961) who found that nurses avoid close and emotional engagement for fear of exposure to stressors and that the institutional and professional cultures of the healthcare service inhibit and devalue nurse–patient intimacy. Participants in my study also mentioned this but attributed the reason for poor communication with patients, to a lack of time available for such interactions. Maguire and

Pitceathly (2002) highlight that doctors also avoid asking questions about the social and emotional situation of their clients when they consult with them in order not to unleash distress that they cannot handle or that may threaten their own emotional survival, especially if they do not feel they can receive adequate support from their colleagues. In my study, doctors also mentioned not having time to communicate with patients. In addition, they believed it was the nurses' role to gather information from the patients about their social and emotional situation. Participants believed these attitudes caused nurses and doctors to shy away from too much communication with patients and with each other. Considerable evidence has been gathered in the literature on the problems of communication within health care as well as on the benefits of good communication (Spencer 2001, Silverman et al. 1998). However, Spencer (2001) suggests that more evidence is required about how communication can best be achieved amongst professionals.

Since ineffective communication was deemed a problem by interviewees in this study, many individuals believed that more training in this area was required to aid collaboration amongst healthcare staff. Pietronic (1994) suggests that communication training is one tactic that aids collaboration and ultimately removes negative stereotyped perceptions between professions. In his 1991 study with undergraduate students (medicine, nursing and social work), Pietrone found distinct occupational identities amongst the students and found them to have strong stereotypical views of each other. Training in communication skills at an early stage would address such problems because students would learn more about each other's roles as they talk to each other. In my study there was also evidence of stereotypical views of other professional groups, which participants believed would be eradicated through training and more collaboration. However, the benefits of training in communication are still not adequately revealed in the literature. Many PRHOs did mention covering the topic of communication at some time during their training but were unable to remember exactly what they had done. Most mentors also mentioned that they had received some training in the area of communication skills. One mentor talked about the benefits of the training she had undertaken and believed its contribution to her work was immense and that it had helped her with patients and colleagues, and in her role as a mentor.

Suzuki Laidlaw et al. (2002) conducted a needs assessment of an integrated cross-curriculum communication skills training programme and an early evaluation of the programme involving undergraduate and post-graduate medical students and full-time faculty staff. They found that communication skills training only occurred in the early days of undergraduate training and was not addressed again. Although their results were based on a low response rate, on self-reports rather than performance and on a few experiences of communication skills programmes, the findings were beneficial in highlighting the need for communication training in medical education. They found that ongoing training, practice and feedback was required, and concluded that, in order to introduce a sustained, coherent and integrated communication skills training programme, there is a need for financial and administrative support and interest from individuals. Findings like these have now been recognised within medical education and have ensured that communication skills are included within medical training. In the curriculum of the foundation years in post-graduate education and training by the Foundation Programme Committee of the Academy of Medical Royal Colleges and the Department of Health (2005), there is a strong emphasis on the training of junior doctors in communication skills, both with patients and with other healthcare professionals. In this curriculum communication with other professional groups has been placed under teamwork and communication. In addition, the General Medical Council's document, *Good Medical Practice* (2006), emphasises the importance of effective communication not only with patients but also with colleagues both within and outside their own medical team. This demonstrates that the medical profession has identified the need for training in team working, which is a step forward for collaborative working.

One method of training is through role modelling as discussed previously in this chapter. Brereton (1995) states that the power of the socialisation process has been recognised as being greater than the influence of teaching. This also relates to learning about communication. Junior staff observe senior staff members' communication skills and learn from their interactions with other professional groups. This is socialisation through role modelling. Mentors in my study observed that junior doctors' behaviour towards nurses and their communication with nursing staff were similar to that of the senior

members of their medical team. They believed that junior doctors learnt the behaviour from senior staff and copied them. This demonstrates that a mentoring project such as in this study allows junior staff to have access to a variety of individuals and hence a number of role models from whom to learn.

Participants identified different ways of communicating, such as basic information sharing or more in-depth communication. For example, participants believed information written in patients' notes was one form of communication (information sharing). Thompson (1986) describes two functions of communication: instrumental (just sharing of information) and expressive (talking about something just because you want to or need to). In my view, communication in health care is about sharing information and more importantly about consultation. Consultation is more than the sharing of information; it is about exchanging ideas and asking for the advice and opinions of others. Proper consultation allows for everyone's voice to be heard and considered. Bahá'u'lláh, the founder of the Bahá'í Faith in the late 1800s, wrote about the importance of consultation and how, in conjunction with compassion, it is the basis for divine wisdom. His son, 'Abdu'l-Bahá, in the early part of the 20th Century wrote about certain prime requisites for those who consult together. These include: purity of motive, detachment (from personal views and wants), patience, humility and lowliness. I strongly believe that these qualities are largely absent in the health service in relation to interactions between different professionals. Participants in my study also mentioned nursing and medical staff not having respect for each other and having their own interests at heart, which according to 'Abdu'l-Bahá, are attitudes not conducive to consultation. John Kolstoe (1995) believes that for consultation to be effective, the individuals involved need to adopt the right attitude and spirit. He describes seven virtues required for consultation and seven attitudes impeding consultation. The virtues are: purity of motive, spirit, detachment, eagerness, modesty, patience and service. Attitudes requiring change are: discord, stubbornness, pride of authorship, discounting, advocacy, criticism and domination (see Appendix G for more detailed description of the virtues and attitudes).

The virtues necessary and the changes in character required for effective consultation are hard to achieve and need constant striving. From personal

experience of working within the health service and examining the views and approaches of the participants within this study, the need for Kolstoe's theory (based on Bahá'í principles of consultation) has become evident. Virtues such as detachment from personal views are not part of practice. The right spirit for collaboration is lacking on many occasions, particularly as individuals enter any encounter with preconceived ideas and personal agendas. There is also breakdown of communication due to some hinderences of consultation identified by Kolstoe's (1995), namely seeking power and stubbornness. Participants mentioned that, during many instances of communication (e.g. case conferences), the medical team dominated the proceedings.

Although Kolstoe's theory is about group consultation, in my view the same principles can be used when consultation takes place between two individuals e.g. practitioner and client or two practitioners. However, within healthcare delivery, adopting a team approach results in better communication between professionals and so leads to an increasingly coordinated service delivery with more prompt referrals between team members and less likelihood of clients falling through services (Bennett-Emslie & McIntosh 1995). Trying to adopt Kolstoe's theory in both team consultation and on a one-to-one basis poses challenges. Within a group setting, if consultation is not facilitated correctly, certain individuals can dominate the group, while others remain silent and let the dominant ones take responsibility. During consultation on a one-to-one basis, an individual is forced to become involved in the consultation and, if the two parties do not agree, the support or view of others is not available and thus decision-making becomes difficult.

Therefore, communication is both an essential factor for collaboration as well as a hinderance if not utilised effectively.

5.3 Contribution of interprofessional mentoring for collaborative working

From the literature on change management, many characteristics are required to facilitate change (Callaly and Arya 2005, McCarthy 2005), although Iles and Sutherland (2001) argue that empirically-based publications in the context of

change management in health settings are relatively rare. However, the literature available does shed some light on the requirements for implementing change. Callaly and Arya (2005) conclude that change requires concerted effort and resources. They also emphasise the importance of shared vision as a driving force if change efforts are to be effective. In order for the vision to be effective it needs to be aligned with the core values of the professions and organisation involved in the change. In this study, the core value for both nursing and medicine appeared to be the efficient functioning of the working environment and better patient care. Both professions were willing to try and change if it meant patients would benefit by receiving a seamless service as a result of a better working relationship between the two groups.

In enabling organisations and individuals to embrace collaboration to improve working relationships, there is a need for new initiatives to generate opportunities for learning about collaboration in practice. Also, individuals and organisations need to contribute to and initiate change: for example, individuals are required whose attitude and practices can change the organisational structure and character, and organisations are needed where the overall ethos and philosophy create an environment that promotes and encourages changes in the attitude and practice of practitioners working within it. It should be noted that the purpose of all this is the improvement of patient care and it is important to note that organisations and individual clinicians have to collectively take responsibility for improving and monitoring the quality of that care (Brockelhurst 1999).

McCarthy (2005) suggests five concepts for creating change: promising small but delivering large, creating a 90-day plan, keeping resistors closed, picking popular battles and finding the right people to help with the change. Since my study was about creating change in the practice setting, some of McCarthy's principles could have been applied to my study. For example, it may have been more manageable to create three-month plans, by breaking the aims into smaller parts and allocating less time to each. Also, during the course of the study, I encountered individuals and organisations that were willing and enthusiastic about interprofessional mentoring and became stimulated and encouraged about the opportunities such a project could generate for health care. These individuals should have been utilised more to promote and lead the

project; as McCarthy points out, it is important to find the right people who are supportive of the project to initiate and maintain it and to overcome negative opinion. In this study, negativity came from those who believed that interprofessional mentoring and education would not bridge any barriers between healthcare professionals, especially as such an approach was viewed as yet another trend in the NHS that would change in a few years time. This latter view is also associated with resistance to change (Gelmon et al. 2000) and it is imperative that strategies are in place to overcome such struggles.

I believe that change is necessary within healthcare to meet the needs of users and to ensure that practice evolves, advances and improves. There have been many changes in the last 10 years within the health service in the UK. These include the decentralisation of services, the development of Primary Care Groups and Primary Care Trusts, the advancement of roles for some professionals such as nurses, and closer collaboration between the different professions and agencies for a more efficient service (DoH 2000a, 2000b, 2000c, 1998, 1997). These changes require individuals and organisations to be flexible and to want to change practice for the better – implementing change is difficult if views and practices are rigid.

Lewin (1951) explains that change involves 'unfreezing' the existing mindset and processes, making the change and then 'refreezing' to establish a new mode of operation. Although this may be a simplistic concept, for some participants it was necessary to unfreeze years of practice and attitude towards other professional groups before refreezing the mindset to one that embraces collaboration and has an understanding of the important contribution made by other professional groups. This process can be difficult to achieve in relation to interprofessional working, particularly as both professional groups have been functioning independently of each other for years. Therefore, the question that arises is how to prevent situations developing that require the unfreezing and refreezing of attitudes with regards to interprofessional working. My suggestion is that this should start during training, as corroborated in some of the literature on interprofessional working (Hall and Weaver 2001, Horak el al. 1998), because I believe that there is a clear link between the socialisation of individuals into their profession (i.e. becoming a practitioner) and the culture of that profession, both having a reciprocal impact on each other.

5.4 Summary

In this study there were defined outcomes and consequences of interprofessional mentoring, which some participants also attributed to the outcomes and consequences of collaborative working. These included improved communication, interpersonal relationships, working relationships and patient care, as well as increased job satisfaction, and increased knowledge of interprofessional learning and working and medical and nursing education. Furthermore, interprofessional mentoring aided mentors' personal development, assisted mentees with their lack of support, and helped mentees to deal with nursing staff and patients.

An interprofessional support system for newly-qualified staff that, in addition to providing support, trains or re-trains healthcare staff to work in this new culture of collaboration by teaching them how to work more effectively with other professional groups is of great benefit. Many staff mentioned the change in culture witnessed within health care in recent years. It was acknowledged by many of the participants that there is a climate of rapid change and uncertainty within the NHS at present, particularly around roles and relationships between services and professions. The idea of a more collaborative approach was in itself a huge change in culture in the view of some participants. Within that idea, there were issues of changes in power status between nurses and doctors, changes in the identity of each profession within health care, changes in communication methods and the need to develop a common vision for care. These also related to the way junior staff are socialised into the workplace and the profession. It can be confusing for the junior staff when the climate requires professions to work closely together to ensure the most effective means are used to provide care, but there are individuals who are still advocate of the old hierarchical style of interaction between healthcare professionals. Therefore, new approaches to and understanding of socialisation are called for. Interprofessional mentoring can assist in the process of developing a collaborative environment.

A realisation for the participants was the number of issues (professional and personal) that can impinge on an interprofessional approach, as an element

of 'catch 22' identified by participants when trying to change a culture from one that has encouraged professional autonomy within the organization, into one of integration and collaboration. Interprofessional and collaborative education and practice in health and social care is one of the many fundamental changes that the new NHS proposes. However as with any fundamental change in culture it will take a tremendous amount of time and effort to change the culture of the NHS.

Chapter 6

Conclusions and recommendations for practice

What this study endeavoured to explore was the experience of interprofessional mentoring within general surgical and medical wards in four NHS District General Hospital. This chapter begins by demonstrating the contribution that interprofessional mentoring made to understanding and supporting the new professionals' transition from novices to confident and competent practitioners. The chapter then concludes with some recommendations for practice, education and research.

6.1 Interprofessional mentoring – another way forward for collaborative working

Within health care today different approaches to collaborative working among health and social care providers are being experimented with to improve services and cost efficiency. A survey of the literature only yielded two other reports of interprofessional mentoring. Both were found to be very limited in their findings. I believe that this study is innovative in that it examines the use of an interprofessional approach to supporting and socialising newly qualified staff into their profession and work place, which has not been done before. This study has shown that interprofessional mentoring can contribute to a change in culture within health care towards one that embraces team working and collaboration, particularly among nurses and doctors. It does this by giving nurses and doctors the opportunity to learn about, with and from each other and creates an environment that allows for dialogue and interaction on a personal and professional level. In order to introduce such innovations there is a need for a change in attitude and culture. Individuals, professions and organisations need to be open to change, willing to try new ideas and have a positive attitude to interprofessional initiatives.

The findings from this study show that mentoring using an interprofessional framework is a viable approach to supporting professionals, particularly during the early stages of their professional life and in the current health service climate. Interprofessional mentoring was perceived as a means for supporting the personal and professional development of newcomers as well as the professional development of the mentors. Professionally it involved learning clinical skills through observation, increasing knowledge about the roles and responsibilities of other professional groups and their contribution to health care, and developing working relationships with other professionals. In terms of personal development, it helped to develop increased confidence and thereby an ability to cope with stress, enhanced interpersonal skills, and improved communication skills.

Learning to become a practitioner was the main theme that emerged from this study, with interprofessional mentoring making a notable contribution to that learning. Role modelling and observation of senior staff was one aspect of interprofessional mentoring, which aided this learning process. In addition interprofessional mentoring provided support and assistance with personal and professional development such as increasing skills, knowledge and confidence in practice. The participants perceived that confidence in practice would also aid communication and collaboration with other healthcare professionals. The interprofessional approach was intended to develop a greater understanding of the role of other professionals within health care so as to increase collaboration and teamwork.

The first few months remain a critical time for new staff in terms of their ability to cope with the changes to their status, role and responsibilities. However, according to the participants, what do appear to have changed are the stressors that impact on the experiences and work of new staff. It can be concluded that experiencing stress is part of the nature of the work, culture and socialisation of healthcare professionals, with the causes of stress altering according to the changes that occur in health care over time (e.g. new reforms, ways of practice, policies). One constant factor appears to be the need for support and learning opportunities particularly in the early days of practice. Therefore, the source, type and amount of support provided to help new staff cope with the transition from student life to practice, needs to be regularly

reviewed, evaluated and examined, with appropriate interventions introduced. A unique feature of interprofessional mentoring was the additional support given to junior doctors that was readily available and accessible, and which was divorced from their competency assessment. This provided them with an understanding about the functions and contributions of other healthcare professionals (nurses) towards patient care.

Interprofessional mentoring was beneficial in many ways for both individuals and the clinical setting. For the newly qualified staff, it proved to be an aid to coping with the stresses of initial practice, an additional resource and a means of socialisation into practice, particularly in relation to collaborative working and communication. The nurse mentors benefited in that they gained a better understanding of the training and background of medical staff and the strains on new doctors, and ultimately achieved a better working relationship with junior medical staff. The advantages of interprofessional mentoring also extended to the clinical area and to patient care. This was attributed to an increase in understanding of the different roles and the development of interpersonal relationships between mentor and mentee.

It is hoped that, as a result of this study, a model of interprofessional mentoring might evolve that would serve to benefit graduates, supporting them through the process of becoming a practitioner and in their socialisation into the practice setting, their profession and the healthcare service as a whole. The model can also demonstrate how this approach can aid a pattern for continual professional development with an interprofessional perspective. Although the study focused initially on a specific practice setting (acute hospital wards) and a specific group (graduates), it became obvious early in the study that the concept of interprofessional mentoring can be applied to many circumstances, where any two or more professionals are working together in a clinical or educational setting. An example could be within specialist areas, such as intensive care, where doctors and physiotherapists enter the arena either because they wish to specialise or experience the clinical setting as part of a training programme. They both would have common needs regarding socialisation into the clinical area and basic learning requirements for the specialist field. Although this study found that interprofessional mentoring aids socialisation into a profession and into healthcare for new staff, it can also be

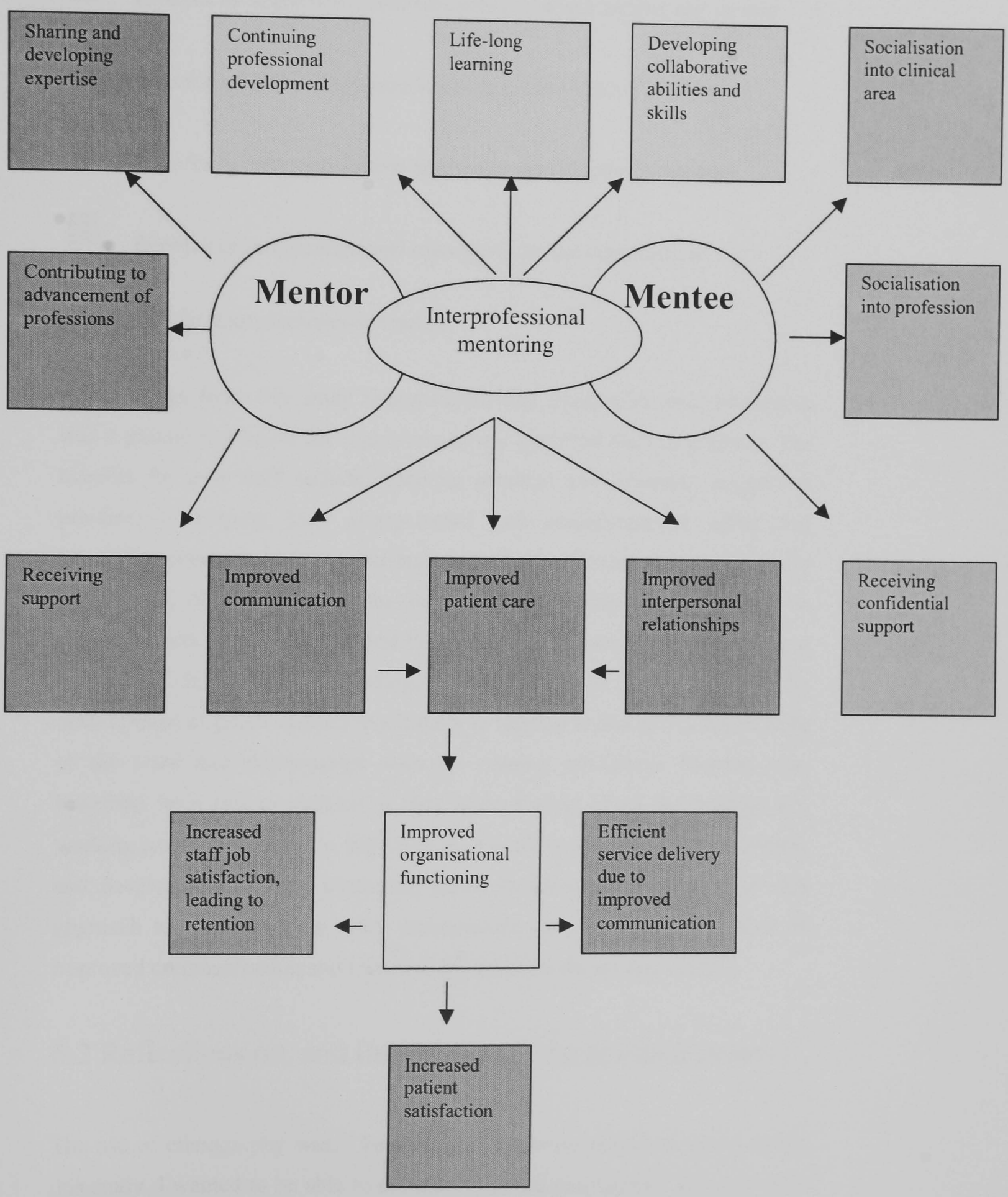
about socialisation into a speciality for senior staff, which can occur through a similar mentoring system with senior specialist staff. It also provides a strong foundation for an interprofessional approach to continuing professional development (CPD). Appendix H demonstrates how the model of interprofessional mentoring developed from this study meets the aims of CPD as outlined by SCOPME (1994).

The changes in and development of new roles and responsibilities, as well as the acquisition of new skills, cannot be carried out in isolation from the needs of the healthcare system and relationships with other healthcare professionals. The way in which junior and senior staff function, the way that nurses and doctors interact and the way their relationships with patients develop must be considered within the context of the organisational structure in which they exist. The model of interprofessional mentoring, applicable to any stage of professional development, provides the opportunity for healthcare staff to learn and grow together in the practice setting. Links with higher educational institutions that support learning in practice are imperative, particularly if mentoring is to support professional development. If interprofessional learning and working are to be part of the culture of the healthcare system, there needs to be continuous involvement and collaboration of individuals, employers, healthcare providers, educationalists and the allied professions.

Interprofessional mentoring benefits individuals, their profession and the organisation, each in turn impacting on the other. This is achieved by increasing the human resources for both professions, better understanding of roles and responsibilities, improved communication between nurses and doctors leading to more efficient use of resources.

As shown in this study, both the individual and profession influenced the socialisation of the graduates and their transition to becoming a practitioner. I believe that collaboration needs to occur between individual practitioners, professional groups and bodies, and the organisations involved in health care i.e. providers and educators. When planning activities for healthcare employees, consideration needs to be given to other professional groups and to organisational factors. Interestingly, in this study most participants pointed out that for interprofessional working to occur successfully, all those involved need to have one common aim, which they identified as being around the needs of

the patient. Figure 4 summarises the benefits of interprofessional mentoring for the mentor and mentee as well as for the working environment and organisation.



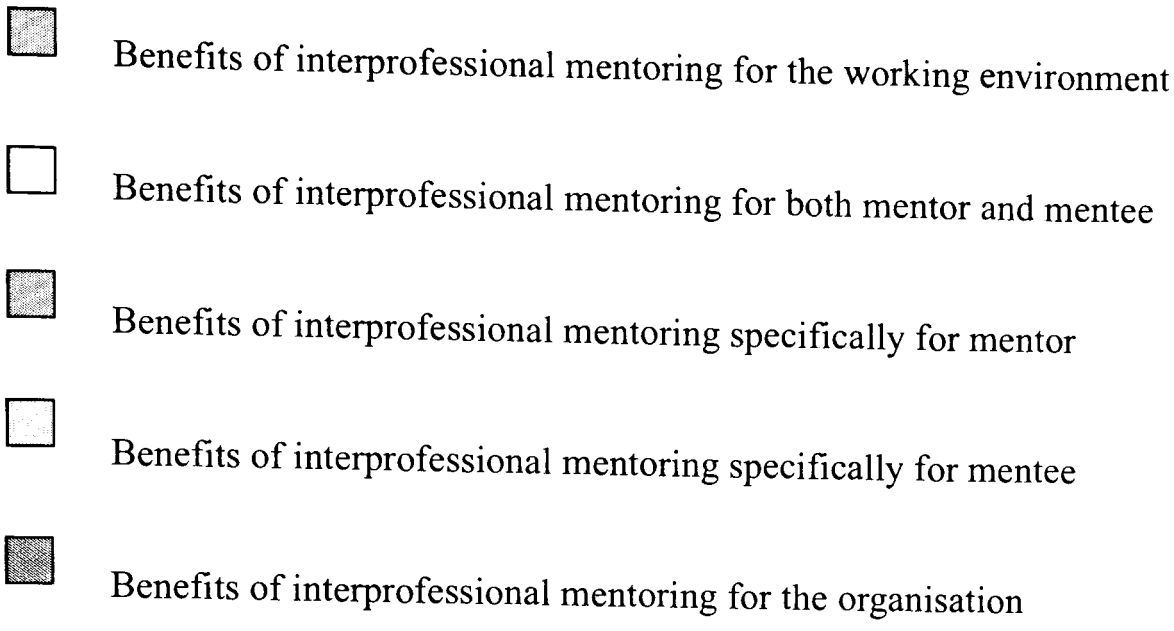


Figure 4. Benefits of interprofessional mentoring

The findings from this study demonstrated that interprofessional mentoring was a practical solution for supporting newly qualified staff in practice. The benefits for new staff include receiving personal and educative support in practice, developing their interpersonal and communication skills and becoming more aware of the contribution of other professional groups to health care. It was clear that one professional group can easily mentor another on certain aspects of their work, unless the individuals themselves are unwilling to be involved. In this study the findings showed that nurses can contribute to the development of junior doctors specifically in relation to day to day functioning of the ward and relationships with the nursing profession. Mentors also benefited from this experience as they learned more about the training and working practices of doctors, improved their working relationship with doctors and developed their own mentoring skills. In addition, as a result of this approach to mentoring, the work environment was enhanced as a result of improved communication and relationships between nurses and doctors.

6.2 Reflections on, and limitations of, the research process

The use of ethnography was, I believe, the best methodological approach for this study. I wanted to be able to describe from the participants' point of view

how interprofessional mentoring influenced their practice, their views about the role and contribution of other healthcare professionals and their perception of changes to patient care as a result. In addition, the culture of both professions was under investigation because each profession has a history of developing a system of functioning and practice, which also impacts on their relationship with other professional groups. This study moved the boundaries of some of those practices and systems for both professions, and the use of an ethnographic approach allowed me to explore the two cultures and the changes to those cultures made as a result of interprofessional mentoring.

Although I believe that the research approach used for this study was appropriate, I feel there is a need for further research in this area. The time period for the data collection was only six months and to be able to explore the long-term benefits of interprofessional mentoring on practice and on the culture of nursing, medicine and healthcare, a longer period of examination would be required. I would suggest that with sufficient funding an action research approach would allow for a group of junior staff to be followed for at least three years until they have become more senior, receiving continuous interprofessional mentoring throughout that period. The first two years for junior doctors is the most difficult and stressful period, according to participants in this study. Therefore, a three-year study would examine the benefits of interprofessional mentoring for alleviating stress for junior doctors in the first two years of their working life. In addition, the third year of the study would explore the attitudes of the same doctors towards other healthcare staff once they have become more senior. The advantage of using action research is the opportunity to make changes to the interprofessional mentoring in order to improve it, based on the experiences of the participants.

In summary, I would suggest that ethnography has been a suitable approach for this study and would advocate future, longer-term studies in the area, possibly using an action research approach.

6.3 Recommendations

The following recommendations are based on the findings of this study and I hope they will be useful to those who may be considering the implementation of an interprofessional mentoring scheme.

6.3.1 Interprofessional mentoring

- The preparation of students during training for collaborative working should be done through a variety of means. For example, in educational settings there could be shared learning/workshops and problem-based learning with other professional groups; in practice settings, some of the working time could be spent with other professional groups or on wards with strong collaborative working patterns.
- Training for senior medical staff should be given in the area of mentoring, as well as on nurse training and practices. It would be useful for novice mentors to observe more experienced mentors in order to learn from them.
- More information about the training of medical staff and their initial needs on qualifying could be incorporated into the mentor training for nurses.
- Eventually, interprofessional mentoring could be available for all professional groups. Most aspects of mentoring can be learnt in conjunction with other professional groups, such as providing support, supporting the learning process and acting as role model. However, all professional groups need to assess the competency of new staff and thus some aspects of mentor training may be profession specific.
- Mentors and mentees who are more likely to have the opportunity to work together should be linked for the purposes of mentorship. For example, consultants are not accessible to newly qualified nurses due to their hours of work. Therefore, it would be more advantageous to have a senior house officer or junior registrar as a mentor. The same theory applies for PRHOs who could work more closely with E and F grade nurses rather than charge nurses as they are usually more occupied with management work than hands-on practice on wards.

- Interprofessional mentoring can be applied to any grade. For example, consultants or senior registrars can easily support the educational needs of senior nurses, such as, nurse consultants or nurse practitioners, in the same clinical speciality.
- Several social meetings between mentors and mentees so that they become familiar with each other before the commencement of their post. An example would be to invite nurse mentors to a lunch during the PRHOs' induction week.
- Clear guidelines for mentors, mentees and all hospital staff about the aims and objectives of the interprofessional mentoring programme.
- The process must receive the full support and backing of management and senior staff.
- Time should be allocated for training mentors and for meetings between mentor and mentee.
- Interprofessional mentoring should be incorporated as one of the support systems within the hospital. This would mean the inclusion of interprofessional mentoring into the hospital policy.

6.3.2 Research process

- Ensure adequate funding is available for the length of the study.
- Staff participating in the study could be involved in the research process for many reasons. It allows the development of research skills and understanding by practice staff, which is important considering the current emphasis on evidence-based practice. Involving staff can be a cost effective way of using resources since the practice staff are already on the wards. If observational techniques are being deployed, having a member of staff observing (participatory observation) can be beneficial. Also, clinical staff have better and more regular contact with each other than an outsider who only enters the research area periodically.
- Data collection needs to be efficient. For example, interviews should also be done at the convenience of the participants.

6.4 In final conclusion

I have attempted to share the findings of a scheme that strongly advocates and creates the opportunity for interprofessional contact and dialogue. However, the whole concept of an interprofessional approach to any aspect of health care, such as education or practice, is still in its infancy with only limited initiatives and preliminary research to date. This poses a difficult challenge and requires the development of new ideas and initiatives and the discovery of the best methodological approach to investigate this area.

This study has demonstrated that with adequate funding, long-term plans (broken up into manageable short term goals), and the support of management, and senior and junior staff, interprofessional mentoring can be a viable approach to supporting newly-qualified staff. Furthermore, it can shed light on our understanding of the roles and contributions of other staff, improve communication and collaboration, and ultimately, through influencing the care received by patients, improve staff job satisfaction for staff and a more efficient use of resources.

This study has enabled me to become a more confident and able researcher and I hope that this thesis will help other researchers on their journey and allow them to build on my findings and experiences.

Chapter 7

Reflections on my personal journey

This chapter consists of reflections on this study and on the research process. Embarking on this study has been a personal journey of learning and the following pages will share some of that learning, which includes the development of the research study and question based on my own practice in health care, implementation of the study and finally the research process itself.

For the purpose of this chapter I have used Johns' (1995) framework to give a description of what happened, followed by personal thoughts on my actions. This allowed me to describe the experiences I encountered, my feelings about those experiences and the changes I would make in the future if faced with the same situations.

The epistemological basis of Johns' framework stemmed from Carper's (1978) views of the world and philosophy of nursing. Carper identified four patterns of knowing within nursing (empirical, ethical, personal and aesthetic) in relation to learning through reflection. Johns adds a fifth pattern, that of reflexivity which '*offers a set of cue questions to tune the practitioner into each of Carper's four ways of knowing within a reflexive and temporal context*' (p227). Examples of such questions include:

- What was I trying to achieve?
- How did I feel in the situation?
- How did my actions match my beliefs?
- Could I handle or do this better in similar situations?

Throughout the study, I kept reflection notes to help the research process and my personal development and learning. Reflections and interpretations of situations allowed for the synthesis of ideas, an understanding of the research process and a realisation about my own beliefs, values and approaches to research and my professional group (nursing). This chapter is divided chronologically from the start of the study to the writing up of the dissertation and its completion.

7.1 How the study began

Holloway and Walker (2000) suggest that a good place to start when writing a PhD dissertation is the background, as a means of establishing the rationale for the study and its empirical framework and context. There were many areas that I wanted to explore more comprehensively and, through my nursing experience, I had always been fascinated by the interaction between different professional groups within healthcare settings. I knew that much had been written in the area of interprofessional working but not necessarily as a result of research inquiry. Many individuals have expressed their views and personal experiences of interprofessional initiatives. Although these types of literature add to a general understanding of interprofessional working and learning, they do not replace the need for research in the area. My interest in this area arose from my experiences in practice. As a practitioner for over ten years in acute healthcare settings and in a variety of specialities (medicine, orthopaedics, surgery and midwifery), I had observed a great deal of interaction between different professional groups providing care for the same client group. Working on one ward I would observe the senior members of the nursing and medical professions collaborating together, and in my opinion, this in turn resulted in better outcomes for patients and a happier working environment for the staff. In contrast I have experience of wards where the same two professions were in conflict with each other and as a result mistakes were made, e.g., medication not prescribed or given, and staff retention (as a result of the working atmosphere) was a major problem. Each profession had a different relationship and way of interacting with the other groups, ranging from no verbal communication (notes only) to full communication, collaboration and team working. On medical wards, a basic exchange of information was usual practice, unlike in the maternity department where consultation about each case was common and respect for the knowledge and expertise of each professional group was evident. This showed me that it was possible for two professional groups to work on an equal basis, each bringing their own expertise to the consultation and decision-making process. These

contrasting experiences made me want to examine what made some professionals work effectively together and why others found it hard to collaborate with different professions. I wanted to know if there was a way to prepare health care students for interprofessional working.

During this study, the interviews and my observations while visiting the ward showed me that the level of communication between staff was on a basic level, i.e. from notes and during ward rounds. This, along with my own clinical experience, led me to the conclusion that general acute wards are not always conducive to collaborative working and so have more need for initiatives like interprofessional mentoring to create an environment for dialogue. Another observation was the power that senior staff (such as consultants and charge nurses) had in shaping the level of interaction between the various professional groups. For example, in those Trusts where the clinical tutors and project leads were enthusiastic and supportive of interprofessional mentoring, the project ran more smoothly and the staff were generally more willing to take part. Finding individuals who are advocates and supporters of an idea is imperative if an initiative is to be successful, particularly in the current state of the NHS where new ideas and demands are continuously placed on staff.

I wanted to explore the area of interprofessional working and mentoring in a new way. The concept of one professional group being supported by another was a novel one and had not been used or widely written about. Only two other similar initiatives were identified in the literature (Bellman 2002, Pearce and Blainey 1999), which for me was a great surprise. I believed that this approach to mentoring would provide the setting for interprofessional working and learning to occur and where the dynamics of power and knowledge could be explored. I was intrigued to see if my own perceptions about the power struggle and the perceived differences in the knowledge base between the two professions would influence such a mentoring scheme.

After ten years of working in clinical practice, I became discouraged at the lack of opportunity for nurses to assess their working environment and practise in a meaningful way for their own benefit and for service improvement. In nursing more so than midwifery lack of control and power can be frustrating. I decided to move into midwifery, which I believe gave me more autonomy. However, even in midwifery elements of medical control over patient care

were apparent. For example, when I was in practice, pregnant women had to be under the care of a consultant even if they never saw the consultant or required medical intervention. The reasons for not having autonomy ranged from lack of training in research, lack of funding opportunities for nurses, lack of incentives, and more concerning, a lack of confidence in their own ability and expertise. This could be the result of poor training, or a combination of the culture within health care and society's image of healthcare professionals, which advocates that doctors have greater knowledge and are therefore given more power within health care (Cruess et al. 2000, Turner 1987, Clifford 1985). These views were expressed by my colleagues, particularly the lack of funding opportunities for nurses to undertake research, as well as few opportunities for further and higher education. This led me to change my career path from midwifery and join a university that has strong collaborative partnerships with practice and prides itself on developing practice.

Currently, the ideologies, methodologies and organisational culture are not amenable to aiding practice development in a sustainable way (McCormack et al. 1999). The lack of funding for nurses to take time out to examine aspects of nursing care is a problem. The new NHS Plan (DOH 1997) and the Government's modernisation agenda are now calling for more evidence-based practice and the involvement of staff in quality improvement. This has started to open doors for nurses to be at the forefront of change particularly with the establishment of practice development units/wards (PDUs). However, according to McCormack et al. (1999), nurses are pressured into being seen to be involved in practice development without a '*systematic approach or underpinning methodology, strategic direction or individual support*' (p257). This study was, therefore, an opportunity to examine the attitudes of healthcare professionals to the development of practice and research. It was not the intention to examine attitudes to research, but it became obvious that there were issues of uncertainty, work pressures and lack of familiarity that prevented individuals from becoming involved in research for the purposes of practice improvement. Therefore, as an academic researcher, I have aimed to ensure the involvement of clinicians in practice settings in order to give them the experience and knowledge of the research process so that they may undertake other studies in an effort to improve practice.

Access to the Trusts was another obstacle. Three out of four Trusts felt they did not have the resources to involve their staff or did not understand the immediate benefit such a project could bring. This was also true of individuals who were approached to participate. A project like this has more long-term benefits and may not be of interest in modern organisations, which often desire instant outcomes (although participants identified some immediate benefits for both the individual and the practice settings). Lessons learnt from this have been twofold. First, making collaborative bids with Trusts from which they may gain some financial benefits is one approach to ensure Trust support. Second, involving individuals in the study or providing some sort of incentive (either financially or with academic credits) may guarantee the willing involvement of individual practitioners.

Once the funding had been secured and four Trusts had agreed to take part in the study, I needed to meet and consult with the heads of nursing, chief executives, clinical tutors and anyone else suggested by the Trust. During these encounters, and through the training of mentors and introductory sessions for PRHOs, I became aware of my own beliefs and values and was conscious of my own attitude and behaviour in the presence of different professional groups. I felt a need to be accepted, valued and respected by them in order to be able to implement the project. This was because of my experience of the healthcare system and my wish for the project to be accepted by the Trust and the staff. For this reason I wanted to ensure that the presentation of the project was suitable for all those who were asked to be involved. The following are my reflections on the meetings I had with the two professional groups when I introduced the project and asked for their participation. It also highlighted my own professional identity.

Meetings with clinical tutors and PRHOs

I believed that the medical profession would be the hardest to involve but their support was crucial for the project. I perceived that the study would not be credible or accepted by them if it was introduced by a nurse, and so I did not divulge my professional background but introduced myself as a research fellow from the university involved. I believed that medical staff would relate better to the study if it was not perceived by them to be a nursing project. On reflection I

think I did not believe in myself, in the idea of interprofessional mentoring or in the medical personnel involved in this study, which could have had implications for this study. However, I attribute this to my own training and socialisation into health care and the nursing culture, which up until recently has been perceived as a profession that is not as valued or as academically capable as other healthcare professions. This view must have informed my thinking and therefore caused me to disassociate myself from my profession in order to try and be accepted. If I am promoting the concept of interprofessional practice that advocates respect for the knowledge and contribution of each professional group, I should be confident in my own background and expertise.

Meetings with heads of nursing and nurse mentors

The tensions between practice and academia have been long-standing and, for many years, nurses in practice found a division between themselves and nursing lecturers. Therefore, I had reservations about introducing myself as a researcher from the university. I felt compelled to divulge the fact that I was a nurse and midwife and believed this gave me credibility among the nurses. This made me more confident to work with them and made the relationship easier as I was able to relate to their worries, anxieties and experiences by giving examples from my own practice, and thus became sensitive to their needs and frustrations. However, the extent to which I could do this varied between each member of staff. For example, heads of nursing and some of the charge nurses were very confident and fully agreed with the need for collaboration between both providers and educators, and were able to accept and support the study. Some less experienced nurses, or those who trained a number of years ago, found the concept more difficult to comprehend and expressed feelings of disillusionment about working within the NHS and working collaboratively with medical professionals. Particularly with this group of nurses, it seemed more appropriate to relate to their ideas first and then help them understand the importance of the study.

In both the above cases, as a researcher I needed credibility in order to be taken seriously and accepted, and to ensure participation by the nurses and doctors. Looking back, it is clear that these feelings were similar to those of PRHOs who did not want '*to lose face*' in front of their medical colleagues and

so would not make use of additional support available to them. They, too, tried to live up to an image that they believed was expected of them. For example, they felt that they were expected by nurses to know everything and be able to carry out clinical procedures. This idea had developed over their five years of training in medical school through input from other medical staff and as a result of limited interactions with nursing staff. This was true of my own beliefs that had been developed during nurse training and in the first few years of practice as a junior member of staff. Clearly, the socialisation of healthcare staff and the development of attitudes begin early on and have a strong influence on interactions with others and on practice. The same was true for the senior nurses acting as mentors as they had apprehensions about mentoring doctors because of uncertainties about being accepted as experienced and knowledgeable professionals. Therefore, a crucial element for ensuring the success of any interprofessional activity is respect among the professional groups. This also includes any collaborative ventures between health providers and educators. Projects such as interprofessional mentoring provide the opportunity for a better understanding of roles and responsibilities, and a respect for and valuing of the contributions of others.

Hence, the attitudes of professional groups were an important factor in this study because they impacted on how practitioners approached the project and each other. I was able to observe what people did and said during interviews and particularly during training days. Most commented on how more senior staff, who had undertaken their training a number of years ago, had a more negative attitude towards the project and the concept of interprofessional working. It was also perceived by many that older practitioners signed up to the hierarchical ideologies that have been so prevalent in healthcare.

With the uptake of this ideology, certain attitudes develop towards other professionals. For example, nurses sometimes believe doctors to be arrogant and disrespectful of nurses, while many doctors perceive nurses as too emotional and not willing to take responsibility (according to participants in this study). Although I was able to observe some of these descriptions and attitudes among long serving professionals, interestingly the same views were also present among newly qualified and junior staff. This demonstrated again the impact of role models and socialisation whereby attitudes and beliefs get

passed down from one generation to the next. I have now realised that no assumptions should be made about participants during research studies and a researcher will always have to be ready to deal with changes and challenges. Fetterman (1998) points out that ethnographers begin with biases and preconceived notions about how people behave and what they think. I believe I had some predetermined ideas about how certain professional groups or grades would react to this study. For example, I thought junior doctors would be more in favour of such a support system than the senior staff, due to changes in their training and the emphasise on collaborative working (GMC 2005). However, this was not the case. I also believed that more senior nurses, who had been trained many years ago, would not be in favour of interprofessional working and hence not make a good mentor. This, too, was not the case. Having prior assumptions or biases are not completely undesirable as long as they are made explicit, are acknowledged and so far as is possible, not impact the study.

The greatest learning from these encounters was a realisation of my own beliefs, views, attitudes and interaction with different healthcare groups. It is clear that no one can remain completely objective and divorced from personal views about the subject under study because previous experiences and attitudes developed over the years will have their influence. Any researcher has to uncover her assumptions and preconceptions. As Mulhall et al. (1999) point out, a researcher's background will affect the conception of any research and the role assumed in setting up the project and the data collection.

From the early stages of this project it became evident that practitioners gave little attention to research on socialisation and care in clinical settings. Obstacles placed before research projects and the lack of priority given to them by many practitioners has made it difficult to maintain enthusiasm and support for any research activity. This will be the main challenge if those involved in health care want to create a culture and environment where evidence-based care has a central place within health care. On several occasions senior individuals within the Trusts expressed negative opinions about the benefits and validity of this study some of which could easily have dissuaded me, had I not had the support and backing of the university and confidence from experience in research. For example, because medical professionals are used to randomised control trials, they did not fully understand or appreciate the value

of a predominately qualitative study and requested a control group for comparison purposes. Also, some senior nurses expressed how this study only overburdened nurses on the wards and was of no benefit to care delivery. Clearly, practitioners who, unlike myself, do not have the support of another organisation, need to feel valued when they pursue research activities if they, in turn, are to value research and understand its place in service delivery. This encouragement and support must come from senior staff, particularly at management level, and will need to include funding, time and adequate access to resources (e.g. library, IT). My impression during the study was that encouragement generally appeared to be lacking in the health service and among health professionals. Training alone does not necessarily inspire individuals to undertake activities, but training teamed with encouragement will empower an individual to advance their practice. The culture of encouragement is not prevalent within health care, especially among medical staff; as demonstrated during this study, PRHOs believed they had to struggle on alone so as not to appear weak or incapable.

7.2 Reflections on the research process

At the start of the study I was unclear about the direction the research project would take and the methodological approach that would best suit it. Any researcher first needs to have a clear understanding of the different methodologies, disciplines, philosophies and paradigms that shape the methods and approaches to data collection and analysis. Also, the debate around qualitative versus quantitative methods has been long and is still unresolved (Patton 1990). According to Patton (1990), there are no rigid roles to follow for making a choice about which methodology to use, asserting that the process is as much an art as it is a science. However, certain questions have to be asked to help inform a choice, such as what kind of information is needed or what resources are available. Initially, I was unsure about what information I needed. There were many factors involved, like the introduction of two major approaches and concepts into practice, i.e., interprofessional collaboration and mentoring. According to Ryan and Hassell (2001) *'the research question*

should always determine the methodology and once the purpose of the research is identified certain methodologies will clearly be better suited than others in addressing the question posed' (p22). Deciding on the methodology to use was the most difficult aspect of this study. It was not just a matter of what methodology would suit the research question but also what implication the setting would have on the choice of research method used. For example, would I have easy access to junior doctors or the ward setting? Would staff have time to take part in interviews or would questionnaires be easier for them?

Having a nursing background also influenced my decision-making process. As a nurse I am aware of the history of research practices within nursing. The positivist paradigm, which has dominated medicine, has also influenced nursing and continues to do so to a degree (Kneebone 2002, Bonell 1999). However, the influence of post-positivism and qualitative methodologies in nursing research has grown but their acceptability is still questioned by health professionals (Kelly 2000).

I wanted to know how mentors and mentees felt about the experience of interprofessional mentoring, what benefits or disadvantages there were and whether it influenced their relationship. As the research focussed on the change in the culture of nursing and medicine ethnography appeared to be the best methodology. The process of choosing the methodology again questioned my own beliefs and tested my confidence in my professional background. I perceived that the medical profession would not accept a purely qualitative approach. The flexibility of the ethnographic approach allowed the use of different methods of data collection, which would have meaning for both professions, for example interviews and questionnaires.

Observation is a crucial element in true ethnography (Brewer 2000). I had been immersed in the healthcare system for ten years and was no stranger to the setting; nor was I naïve about the interactions between the professional groups and the politics involved. For example, working on a medical ward, I experienced an environment where only senior nurses were allowed to communicate with doctors about patients and only the ward sister and two other senior nurses were permitted to go on the ward rounds. I did undertake some observation of the study from a distance during my interaction with the Trusts, i.e., meetings and training sessions, and during data collection. This

provided a rich description about the culture of health care and the influence of mentoring on that culture. Although participatory observation could have provided even more insights, I believe my own experience within the healthcare setting gave me a flavour of that culture which was adequate for the purposes of this study. Future studies in this area may require more observational methods of data collection.

This study captured key moments in time for novice practitioners: at the beginning of practice and six months after initial practice by which time they had gained some experience of interprofessional mentoring. This provided me with important data about the socialisation of junior staff into health care and the influence of interprofessional mentoring on that process. Ethnography provides a description of a culture or situation, and through this methodology I was able to explore the perceptions of participants based on their experiences. Participants pointed to possible long-term benefits of interprofessional mentoring, such as junior staff developing skills to become future mentors or having a more positive attitude to collaborative working.

Since the socialisation of junior staff into their professional culture takes many years, it is difficult to expect a six-month exposure to a new way of functioning to be sufficient to change the attitudes and practices of individual practitioners. Although benefits were identified after six months, another follow-up study a year later would have provided more insight into the long-term benefits of interprofessional activities on the attitudes and interactions of junior doctors with nurses and other healthcare professionals.

Another issue with the research process was how to combine the PhD study with an existing, funded project. Initially this study was the result of a successful bid with commitment to the funding body to provide an evaluation on completion of the project. It is vital that PhD students in the same position ensure that their personal requirements are also met during the study and that clear guidelines and agreements are made beforehand. Organising the research and accessing participants are time consuming and dependent on the funding. Conducting a PhD study on its own is challenging enough without the added pressure of delivering for a funding body or organisation. However, opportunities and funding for PhD studies are limited. Individuals, particularly

those in practice, will have to use any opportunity to further their educational needs which may mean the added pressures from funding bodies.

7.3 In conclusion

In reflecting on my experiences during the undertaking of this study, several issues came to light. First, my own professional background and experiences influenced not only the development of the research question and the study but also my interactions with the participants. I realised that the negative aspects of my time in practice, such as poor communication amongst staff, moments of conflict between healthcare professions and not being respected or valued for what I did or thought, probably brought about this desire to find ways of improving the working relationship between health care staff, particularly nurses and doctors.

Second, I found that my personal experiences as a researcher and the need for acceptance were similar to those of the participants in this study. At the start of this study I too, identified myself as a different person depending on the professional group I was interacting with, i.e. a nurse with the nursing staff and a university researcher with the medical staff. I, therefore, related to the junior doctors and felt their anxieties and their approach to dealing with those anxieties.

Third, during any research activity, reflection is vital to ensure the richest data is collected. For example, if access to participants for interviews becomes difficult, a researcher will have to decide whether to change the target population or use a different approach to data collection, which might be easier to undertake while still providing rich enough data. Through reflection I have been able to identify aspects of the study that I could have done differently, along with a possible suitable follow-up study to gain more insight into the topic area and move interprofessional mentoring forward as a concrete support structure within health care.

Finally, I have learnt some of the obstacles to research activities in practice and the challenges individuals face when undertaking a PhD study. Through this insight and personal experience, I aim to be of assistance in the following ways:

- Support practitioners where possible in undertaking research activities;
- Teach student nurses the importance of research and ways for them to obtain funding or to become involved in research activities;
- Advise PhD students about some of the challenges they may encounter and give possible solutions.

Also in final reflection I believe the benefits of this approach to mentoring were:

- More support for junior doctors;
- Personal development of mentors;
- More dialogue between nurses and doctors;
- Better understanding of roles, responsibilities and training of each professional group;
- Improved working relationship amongst nurses and doctors;
- Improved communication between nurses and doctors;
- Improved patient care.

Appendix A

Development/identification of the topic areas for interviews

Stage one

Literature review, findings from a funded study by Bournemouth University and personal experiences. I wanted to know how newly qualified doctors felt about their new role and how they felt they could be supported by another professional group (nurses) on their professional journey. In addition I wanted to find out if this framework for mentoring could aid collaboration between the different professional groups.

Stage two

Meetings with various individuals both at the University and the Trusts involved in my study

Stage three

Development of the pre-questionnaire, which was shared with experts for their review

Stage four

Development of question guide for the pre-interviews, which was shared with experts for their review

Stage five

Development of the post-questionnaire based on the findings of the pre-questionnaires and interviews, which was shared with experts for their review

Stage six

Development of question guide for post-interviews based on the findings of the pre-questionnaires and interviews, as well as the findings from some of the post-questionnaires

Appendix B

Below are the pre- and post- questionnaires given to the participants in this study.

Pre-questionnaire

Interprofessional mentoring

Farnaz Heidari

Coordinator

Institute of Health and Community Studies

The interprofessional scheme you are going to be involved in is new to this Trust. It is, therefore, crucial that we examine its impact on participants and explore the influence of this project on your working and learning environment.

One aspect of this study is the completion of a questionnaire **at the start of the project and this will be repeated after six months.**

Your participation in this innovative scheme and the research is important. All information will remain anonymous. No names will be used and no individual will be identified. The only person with access to the data will be the Coordinator.

We would like to thank you in advance for taking part. If you have any questions or would like more information please do not hesitate to contact Farnaz Heidari:

Bournemouth University
Institute of Health and Community Studies
Royal London House, Christchurch Road, Bournemouth, BH3 1LT
Tel: 01202 504182
Email: fheidari@bournemouth.ac.uk

Section One

Demographics

1) Please indicate your gender by circling the appropriate response

Male Female

2) Please indicate your age by circling the appropriate response

21-30 31-40 41-50 51+

3) Please write which clinical area you are currently /will be working in

4) How long have you been practicing? (To be completed by Clinical Tutors, Project Leaders and mentors only. Please circle appropriate response)

Up to 5 yrs 6-10 yrs 11-15 yrs 16-20 yrs 21+ yrs

5) Ethnicity. Please tick the appropriate response

White Chinese

Black-Caribbean Black-African

Black-other Indian

Pakistani Bangladeshi

Other - specify

Section Two

General questions about interprofessional learning/working

1) Do you have any previous experience of interprofessional learning/working?

Yes No Not sure

2) If yes, please state in what context.

3) Please write any other comments you would like to share about interprofessional mentoring/learning/working.

4) What, in your opinion, are your greatest needs as you start your new role?

5) Any other comments:

THANK YOU FOR TAKING THE TIME
TO COMPLETE THIS QUESTIONNAIRE

Post-questionnaire

Interprofessional mentoring

Farnaz Heidari
Coordinator
Institute of Health and Community Studies

The interprofessional scheme you are going to be involved in is new to this Trust. It is, therefore, crucial that we examine its impact on participants and explore the influence of this project on your working and learning environment.

One aspect of this study is the completion of a questionnaire **at the start of the project and after six months.**

Your participation in this innovative scheme and the research is important. All information will remain anonymous. No names will be used and no individual will be identified. The only person with access to the data will be the Coordinator.

We would like to thank you in advance for taking part. If you have any questions or would like more information please do not hesitate to contact Farnaz Heidari:

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Institute of Health and Community Studies
Royal London House, Christchurch Road, Bournemouth, BH3 1LT
Tel: 01202 504182
Email: fheidari@bournemouth.ac.uk

For mentees

Your experiences

1) To what extent did each of the following affect your stress levels during the first few months of your professional life. Please tick one box for each category that is most appropriate to you. If a category is not applicable please leave blank.

	Increased my stress significantly	Increased my stress a bit	No effect on my stress	Decreased my stress a bit	Decreased my stress significantly
Other PRHOs					
SHOs					
Registrars					
Consultant					
Educational Supervisor					
Clinical Tutor					
Post Graduate Manager					
Nurse Practitioner					
Senior Nurses					
Junior Nurses					
Nurse Mentor					
Professionals Allied to Medicine					
Others, please state:					
1)					

2) Please clarify any of the above answers.

3) To what extent did each of the following contribute to your educational development. Please tick one box for each category that is most appropriate to you.

Other PRHOs	A lot	Moderate	Slight	Not at all
SHOs				
Registrars				
Consultant				
Educational Supervisor				
Clinical Tutor				
Post Graduate Manager				
Nurse Practitioners				
Senior Nurses				
Junior Nurses				
Nurse Mentor				
Professionals Allied to Medicine				
Core Curriculum				
Joint Interprofessional Workshops				
Others, please state:				
1)				
2)				

4) Please clarify any of the above answers.

5) To what extent did each of the following affect your stress levels? Please tick one box for each category that is most appropriate to you.

	Increased stress significantly	Increased stress a bit	No effect	Reduced stress a bit	Reduced stress significantly
Work load					
Responsibility and accountability					
Long hours / shift patterns					
Medical staff					
Nursing staff					
Lack of support					
Patients					
Educational requirements					
Others please state:					
1)					
2)					

6) To what extent did having a mentor help you manage your stress with the following?

	Significant +ve effect	Slight +ve effect	No effect	Slight –ve effect	Significant –ve effect
Work load					
Responsibility and accountability					
Long hours / shift patterns					
Medical staff					
Nursing staff					
Lack of support					
Patients					
Educational requirements					
Others please state:					
1)					
2)					

7) Please describe your experience of the mentoring scheme.

8) From whom did you receive most of your support?

9) Do you feel you were supported by your mentor?

Yes No

10) Please clarify the above answer by explaining how you felt you were/were not supported.

11) Would you change anything about the scheme?

12) Any other comments.

THANK YOU FOR TAKING THE TIME
TO COMPLETE THIS QUESTIONNAIRE

For mentors

Your experiences

A) Please circle one response for each sentence that is most appropriate to you.

The Interprofessional project has:

1) Prepared me for my role as mentor

A lot **Moderate** **Slight** **Not at all**

2) Helped my own personal development

A lot **Moderate** **Slight** **Not at all**

3) Increased my knowledge of medical education

A lot **Moderate** **Slight** **Not at all**

4) Increased my understanding of Interprofessional working and learning

A lot **Moderate** **Slight** **Not at all**

5) Affected my workload

Increased	**Increased a bit**	**No effect**	**Decreased a bit**	**Decreased**

6) Affected my work stress levels

Increased	**Increased a bit**	**No effect**	**Decreased a bit**	**Decreased**

7) Affected my job satisfaction

Increased **Increased a bit** **No effect** **Decreased a bit** **Decreased**

B) Please circle one response for each sentence that is most appropriate to you.

The Interprofessional Project has affected:

1) Communication between nurses and doctors

Improved **Improved a bit** **No effect** **Worsened a bit** **Worsened**

2) Interpersonal relationships amongst nurses and doctors

Improved **Improved a bit** **No effect** **Worsened a bit** **Worsened**

3) Working relationships amongst nurses and doctors

Improved **Improved a bit** **No effect** **Worsened a bit** **Worsened**

4) Patient care

Improved **Improved a bit** **No effect** **Worsened a bit** **Worsened**

5) Duplication of work

Improved **Improved a bit** **No effect** **Worsened a bit** **Worsened**

6) Others, please state:

C) Please describe your experiences as a mentor

D) Any other comments:

THANK YOU FOR TAKING THE TIME
TO COMPLETE THIS QUESTIONNAIRE

Appendix C

The following table is an example of how the themes and categories developed directly from the quotes by the participants (sub-categories).

Theme	Categories	Sub-categories
Stresses and needs of a new practitioner	Anxieties of new staff	...feel much more comfortable asking a senior nurse colleague because they **don't lose face** in the same way (Int SL 1) ...particularly **on call** when you are bleeped by people, you really need somebody (Int P 8a) Total **fear** I think overrode everything else (Int P 27) Also clinical knowledge and **knowing what to do** in difficult situations (P 215) **Lack of support** (P 538)
	Lack of experience	I shall be able to make sure that **they're getting their experiences** or encouraging them to get their experiences (Int M 32) To make sure that no harm is done to any patient as **a result of my inexperience** (P 223) They come out of medical school with all the theoretical knowledge, having passed finals but now they've **got to learn how to put it into practice** (Int CT 3) ... **communication barriers** which may initially be apparent (M 714) I **don't think they would be able to relate** to a junior nurse (Int P 27)

	Accountability and responsibility	…my **reservations for prescribing** and what to do with a sick patient were comforted a bit after I'd started (Int P 15) Agreeing/disagreeing with a decision to give confidence to go ahead with it (P 229) Surviving on call (P 1116) I didn't know what went where, **what the procedures were**, things like that (Int P 29)
	Need for support	It was really about the pressures of her **on call**, covering the wards and things like that **Being able to ask questions** (Int MD 11) Someone to turn to, to **ask 'silly' questions** (P 533) You were looked after and helped through difficult times or **not knowing what to do** (Int CT 6) I mean I've **observed doctors** under quite a lot of stress, not managing their workload but not feeling able to discuss this with their team (Int M 9)
	Teaching opportunities	…if they weren't happy then of course I would either do it **so that they could watch me or I would go with them if they wanted me to** (Int M 21) Certainly learn from more senior nurses, yeah you do **learn from more senior nurses**. A lot sort of about the practical procedures (Int P 22) I can see a difference in that from what it was a few years ago whereas before they didn't have to get anything **signed to say that they're competent** of doing it, now they do which I think is a lot better (Int M32)

Table 1 – Themes, categories and subcategories as developed directly form the quotes by the participants

Appendix D

Qualitative results

The tables below demonstrate the categories and themes that emerged from the qualitative data. A third column is included which shows some related words and sentences from the data that gave rise to the themes. (Appendix D provides an example of how the theme 'Stresses and needs of a new practitioner' emerged, alongside the direct sections from the data.) Following the development of these themes and categories, they were further analysed, condensed and some attribution of meaning was given to them, leading to two major themes: the journey of becoming a professional in relation to self and the journey of becoming a professional in relation to others (see Table 11). The number of participants who were interviewed were four clinical tutors, four project leads, 12 mentees and 12 mentors.

Theme	Categories	Sentences/words from data
Educational and professional development of doctors and nurses	Medical and nursing education	• Length of study time • Interaction with other professional groups • Links with practice during training
	Various aspects of learning	• Learning about other professionals • Theoretical and practical knowledge
	Different types of learning	• Observing others • From text books and lectures • Carrying out practical skills – doing
	Professional requirements	• Hours of teaching and learning • Support in practice • Teaching in practice
	Various learning opportunities and techniques	• Case studies of patients • Ward-based learning (observation) • Ward-based teaching (i.e. ward rounds) • Interprofessional learning

Table 2. First theme: Educational and professional development of doctors and nurses

Theme	Categories	Sentences/words from data
Stresses and needs of a new practitioner	Anxieties experienced by new staff	• Not losing face • Being on call • Fear • Worries of not knowing what to do • Not having support
	Lack of experience felt by new staff	• Lack of practical experience • Learning to link theory to practice • Lack of communication skills • Not knowing how to relate to other professional groups
	The pressures of accountability and responsibility	• Prescribing • Making decisions • Being on call • Being sure of carrying out right procedures
	The need for support	• When on call • Being able to ask questions • Being informed of what to do • Being observed
	Teaching opportunities for new staff	• Being able to observe others • Learning from all professions • Becoming competent and able to register

Table 3. Second theme: Stresses and needs of a new practitioner

Themes	Categories	Sentences/words from data
Support structures	The best person to support junior staff	• Nursing staff – senior nurses, nurse practitioners • Medical staff – SHOs, registrars, consultants, educational supervisors, clinical tutors • Peers
	The benefits of providing support	• Helping with personal and professional development • Ensuring correct practice • Provision of information • Safeguarding patients
	The times that support is mainly needed	• First few weeks of practice • On call • Carrying out procedures for the first time

Table 4. Third theme: Support structures

Themes	Categories	Sentences/words from data
Expectations of interprofessional mentoring	Expressed needs of mentors	• Support • Training • Respect by mentees
	Expressed needs of mentees	• Support • Teaching • Being informed of their duties • Being accepted by their team
	Interprofessional approach to mentoring	• Mentors having the necessary qualities • No experience of mentoring in medical profession • Formalising the support that nurses have always given to junior doctors • Developing a personal relationship

Table 5. Fourth theme: Expectations of mentoring

Themes	Categories	Sentences/words from data
Perceived benefits of interprofessional of mentoring	The development of mentors	• Professional development • Better understanding of training and needs of medical staff • More awareness of stresses of junior doctors
	The development of mentees	• Receiving support • Access to teaching • Developing confidence • Better understanding of the role of nurses
	Perceived impact of interprofessional mentoring on the working environment	• Improved communication • Improved working relationships between doctors and nurses • Improved personal relationships between doctors and nurses • Improved patient care

Table 6. Fifth theme: Perceived benefits of mentoring

Themes	Categories	Sentences/words from data
Perceived challenges to interprofessional mentoring	Organisational structures	• Patterns of working • Shift patterns • Workload • Ward structures • PRHO rotations • Reduction of junior doctor hours
	Individual members of staff and their influence	• Need individuals best suited for the mentoring role i.e. nurse practitioners • Personalities • Attitudes to working with other professional groups • Views and beliefs about other professional groups and own profession
	Lack of experience of mentoring and interprofessinal working	• Medical profession has minimal experience of mentoring • Doctors have no training for being a mentor • Minimal experience of interprofessional working
	Lack of knowledge about other professional groups and their contribution to health care	• Lack of knowledge of training and education of other professions • Lack of knowledge of roles and responsibilities • Lack of knowledge of working patterns of other professions

Table 7. Sixth theme: Perceived challenges to mentoring

Themes	Categories	Sentences/words from data
Cultures and socialisation of the professions	The functioning and differences of the professional groups	• Power struggle • Own professional practices • Historical perspectives of professions • Hierarchical structures of professions • Unfamiliarity with other professional groups
	Socialisation into one's own profession and the health service	• Importance allocated to the different professional tasks and training • Learning from role models (both good and bad practices and attitudes) • Not enough contact with other professional groups • Traditional training
	Views and attitudes of others members of staff	• Understanding of role and responsibilities of other professions • Stereotypical views of other professions • Negative experiences when working with members of other professions • Expectations of others • Need for professional boundaries

Table 8. Seventh theme: Cultures and socialisation of the professions

Themes	Categories	Sentences/words from data
Experiences and understanding of interprofessional working/education	Meaning and definition of interprofessional working/education	• No consensus • Extreme variations in understanding of interprofessional working
	Experience of interprofessional working	• Varied experiences • Differing degrees of interactions with other professional groups • Experiences in practice and in education • Some clinical areas more suited to interprofessional working
	Benefits and challenges to interprofessional working/education	• Improvements in communication • Improvements in working and personal relationships • Improved patient care • Unwillingness to try by individuals • Reluctance to change practice • Power distribution

Table 9. Eighth theme: Experiences and understanding of interprofessional working/education

Themes	Categories	Sentences/words from data
Need for a collaborative team approach	Need for improved communication	• Levels of communication • Types of communication • Improved communication leading to improved care
	Understanding the roles of other professional groups	• Respect for others • Valuing contributions from other professions • Understanding the value of input from various professions
	Having a shared vision	• Having common goals • Placing service users at the centre of work

Table 10. Ninth theme: Need for a collaborative team approach

Sub-themes	Themes	Major themes
Educational and professional development of doctors and nurses Support structures Stresses and needs of a new practitioner Benefits, challenges and expectation of interprofessional mentoring	Stress and anxiety of practice Learning to become a professional	The journey of becoming a professional in relation to self
Cultures and socialisation of the professions Experiences and understanding of interprofessional working/education Need for a collaborative team approach Benefits, challenges and expectation of interprofessional mentoring	Socialisation into profession and organisation Collaboration to aid practice and assist in becoming a professional	The journey of becoming a professional in relation to others

Table 11. Main themes and sub-themes identified from the findings

Appendix E

Quantitative results

The questionnaire consisted of three parts: demographic information, expectations of mentoring before starting the scheme (mostly open-ended questions), and factors that affected and influenced stress level and educational development of mentees following mentoring. For mentors, the third section of the questionnaire consisted of questions about the impact of mentoring on their own practice and the working environment. The participants included 69 mentors, 64 mentees, four project leads, four clinical tutors and three post-graduate managers.

The questionnaire revealed that the mentors were mainly females (88%), whereas the mentees were almost equally divided with respect to gender (54% female, 46% male). Mentors were mainly between the ages of 31-40 (53% between 31-40, 31% between 21-30, and the remaining 16% were 41plus), unlike mentees who were mostly between the ages of 21-30 (98%). Mentors and mentees were mostly Caucasian (mentors 92% and mentees 80%). The clinical areas for both mentors and mentees were mainly on general medical and surgical wards which traditionally employ newly-qualified staff, and where PRHOs are placed for their first practice post.

	Mentors	**Mentees**
Medical	47%	47%
Surgical	24%	36%

Table 12. Clinical areas of practice for mentors and mentees (percentages showing the main clinical areas)

Following six months of mentoring, the participants were asked to complete a questionnaire. The response rate for the post-project questionnaires was 62% (89 out of 141: 47 PRHOs, 38 mentors, 4 project leads). PRHOs were asked specifically about the level of support they received from their mentors and from other staff in the work place. Fifty-five percent of the PRHOs felt they were supported by their mentor, 17% did not believe they were supported and the rest did not respond to this question. PRHOs were asked to nominate the professional group that supported them most

during the first six months of their practice. Table 13 demonstrates that peer support was rated the highest, followed by senior house officers (SHOs) and nurses.

Who supported you?	Percentage
Other PRHOs	23
SHOs	19
Nurses	9
Registrars	4
Educational Supervisors	2
No response	43

Table 13. Support for PRHOs from different professionals

Table 14 shows the impact of professional groups on the PRHOs' stress levels.

To what extent did the following individuals affect your stress levels?	Decreased stress levels %	Increased stress levels %
SHOs	74	9
Nurse practitioners	70	11
Other PRHOs	68	15
Registrars	60	21
Senior nurses	55	9
Educational supervisors	55	26
Nurse mentors	49	0
Consultants	45	40
Clinical tutors	32	2
Junior nurses	26	38
Allied professionals	23	11
Post-graduate managers	21	4

Table 14. The extent to which other professionals affected PRHOs' stress levels

As shown in Table 14, nurse practitioners were rated highly regarding their effect of decreasing the stress levels of PRHOs. Interestingly, consultants, registrars and educational supervisors were identified as increasing the stress levels of PRHOs.

However, senior doctors, as well as senior house officers, provided the greatest contribution to the educational development of junior doctors (see Table 15).

To what extent did the following contribute to your educational development?	A lot %	Moderate to slight %	Not a lot %
Registrars	64	30	0
SHOs	49	43	4
Consultants	43	51	2
Educational supervisors	23	64	4
Other PRHOs	17	70	4
Core curriculum	15	72	6
Senior nurses	6	83	4
Clinical tutors	6	55	23
Nurse mentors	2	45	38
Nurse practitioners	2	62	23
Post-graduate managers	2	40	43
Junior nurses	0	55	36
Allied professionals	0	53	23
Shared learning sessions	0	49	15

Table 15. Professionals and activities contributing to PRHOs' educational development

The questionnaire aimed to ascertain the factors that influenced the stress levels of junior doctors. Table 16 demonstrates how responsibility and accountability, workload, long hours and shift patterns had the greatest impact on the stress levels of PRHOs.

To what extent did each of the following affect your stress levels?	Increased stress %	Decreased stress %
Responsibility and accountability	85	0
Workload	83	2
Long hours/shift patterns	72	0
Lack of support	60	4
Patients	45	9
Nursing staff	38	23
Medical staff	30	23
Educational requirements	19	0

Table 16. Factors affecting stress levels

PRHOs identified areas that mentors were particularly able to help them with and these included perceived lack of support from others, dealing with patients and nursing staff (see Table 17). Interestingly, during the interviews mentees mentioned how mentors helped them learn certain clinical skills, and yet only a small percentage indicated that mentors had a positive effect on their educational requirements. This may be due to PRHOs associating educational requirements with what they would be assessed on, in order to register as doctors after their first year.

To what extent did having a mentor help you manage your stress levels with the following?	Positive effect %
Lack of support	32
Nursing staff	26
Patients	26
Medical staff	17
Workload	17
Responsibility and accountability	15
Long hours/shift patterns	9
Educational requirements	2

Table 17. Mentors helping PRHOs manage factors that affect their stress levels

Most mentors evaluated the mentoring positively and the following tables (18-20) show their perceptions of the scheme and its effects, as well as their experiences of being a mentor.

Mentor's perception of mentoring	A lot %	Moderate to slight %	No affect %
Helped mentor's own personal development	26	57	17
Increased mentor's knowledge of interprofessional working and learning	19	66	15
Increased mentor's knowledge of medical education	15	70	15
Prepared for role as a mentor	15	64	21

Table 18. Mentor's perception of shared mentoring

What effects did mentoring have on the mentor?	Increased %	No effect %
Affected mentor's job satisfaction	62	30
Affected mentor's workload	53	38
Affected mentor's stress level	26	66

Table 19. Effects of being a mentor

What effects did mentoring have on the working environment?	Improved %	No effect %
Working relationship between nurses and doctors	81	9
Communication between nurses and doctors	79	11
Interpersonal relationship between nurses and doctors	77	13
Patient care	57	32
Duplication of work	21	62

Table 20. Effects of mentoring

The findings clearly demonstrate that the project had positive effects on the mentors' own development and knowledge. Although the project did affect the workload and stress levels of the mentors, it also increased their job satisfaction and improved their working environment. The majority of the mentors perceived that communication, working and interpersonal relationships between doctors and nurses had improved, which in turn improved patient care.

Even after a short period of six months, and despite the limited experience of mentors and the minimal awareness of the project within the participating Trusts, the benefits gained from interprofessional mentoring have been evident as shown above.

Appendix F

Sections from a transcript of an interview with a nurse practitioner who jointly mentored a PRHO and a newly qualified registered nurse.

Why did you feel you didn't do a good job?

As I say they were both remarkably laid back and they very rarely seemed to have any problems, one did more so than the other, but it was just a bit wishy washy. It wasn't as structured as I would have liked it to have been. Now I don't know if it should be structured, but I just feel that I should have been able to give a little bit more structured support. They found it useful because they both said they didn't mind me sharing this with you. I did check. They found it very useful because they learnt a little bit more about each other's jobs and they both now appreciate how frightening and stressful it can be to start off in life in both roles and I did quite often find them nattering to each other on the ward more than you would perhaps see it and gaining support from each other which I thought was very very good, very positive, but I still would have liked to have been a little bit structured, but time didn't allow me to be.

What do you mean by structured what did you have in your mind as regards to this?

The meetings were good and we had them as regularly as we all agreed we wanted them, but I would have liked to have been seen to be more available to them if they had a problem, like a non planned meeting. Does that make sense?

Can I ask with regards to these meetings you keep mentioning that there were no problems. Do you feel these mentoring meetings were just for problems?

No. It was a learning process and as I said they learnt a lot about each other's roles, not that nurses do drug rounds at one o'clock in the lunch time although we do know that now because we can never plan a meeting at one o'clock, but not that sort of thing. For example the staff nurse really did not appreciate that the PRHO was in

school one day and had to know everything that she had to ask him the next day. So she has got a hugely increased awareness of these PRHOs needing her support because she is part of a team she doesn't understand she has got a team member. She also didn't understand that unlike her she is instantly allocated a mentor and preceptor because that is what the UKCC say she has to have. It doesn't happen in medicine. She just assumed that there must be somebody there to support these doctors and there isn't and so we all learnt from that and the PRHO really didn't realize how busy nurses are. He didn't understand their physical daily workload was as extreme as it is. So they both learnt from it.

Can you tell me a little bit more, obviously without disclosing confidential information, what types of things you were able to discuss during the meetings?

There were two problems and again I have checked with both of them and they don't mind the information being disclosed because it was nothing serious. PRHO was struggling managing his workload so we looked at ways of getting around that, and the staff nurse said she could help by doing such and such and we resolved it that way. This is where the difficulty came in because as a nurse practitioner there was something that I could do to change that. So I said look I can make this offer to you but then I was conscious that was difficult to do as a mentor without letting them solve their own problems but I had to make the offer of help and we reviewed it and it didn't reduce the workload but it restructured the workload to a more manageable way. A more manageable way forward and it did work I mean whether it continues I don't know. And with the nurse there was only one main problem she had which was with going to the shared learning sessions. It didn't work at all. She couldn't get the time off the ward. There were three of them wanting to go. We did look at a way of one going and feeding back to the other two and that worked, but she felt it was very medical, she felt it was a little threatening and it wasn't always and she didn't feel there was much nursing input. She didn't like that bit and that perhaps needs to be addressed. In some of the sessions she went to, she felt they weren't relevant but she didn't know until she got there but she didn't know what pitch they were going to be aimed at.

Appendix G

Virtues and attitudes for consultation

(From Discussion Chapter)

The virtues required for consultation are:

- Motive –has to be pure for the purpose of achieving the best result. There can be no room for ulterior motive. With this attitude it does not matter who has come up with the idea being used and no credit is given to anyone since the group have a common vision
- Spirit – the right spirit needs to be created for consultation. The spirit should be one of enthusiasm and optimistic outlook rather than pessimism
- Detachment – in any consultation people have their own views only some of which may be of value. However for consultation to be effective and for the good of the whole then people should be detached from their ideas and able to listen to others and be open to other ideas and approaches
- Eagerness – there needs to be an eagerness for improvement and the finding of the best solution and decision
- Modesty – there is no assurance that good ideas only come from a certain type of person. Therefore it makes no difference who comes up with the good idea or the solution but rather that it is done as a group. Having a superior attitude cuts off creative thoughts whereas modesty encourages them
- Patience – grace under stress is essential. This means not applying quick and easy solutions simply because they are quick and easy. It means calm perseverance while searching for results; maintaining self-control and perspective; persistence and diligence; and above, all, not resorting to complaint and anger
- Service – it is vital that personal interest are put aside and an attitude of service for others is allowed to prevail. Service needs to be the purpose of the consultation.

To aid consultation attitudes requiring change are:

- Discord – a proud or boastful attitude, power plays, manoeuvring for position, trying to bend the will of the reluctant and ego games are counterproductive, dangerous and poisonous to group thinking
- Stubbornness – stubbornness and persistence in one's own views and the incessant defending of an idea can cause discord, wrangling and stop creativity within group dynamics
- Pride of authorship – every contribution is important to the group but once given it belongs to the whole group. Therefore no one person takes the credit and if ideas are criticised it is not a criticism of an individual but the group's ideas. This takes practice and patience
- Discounting – both verbal and non-verbal gestures when someone is presenting their idea dampens creativity and causes discord amongst group members. Discounting other members or their ideas only serves to hurt the working relationship of the group
- Advocacy – one has to have their own views rather than advocate another person's view (in a health setting one should have their own opinion rather than how they think their profession should be presented). One has to remember the advocacy is for the patient
- Criticism – takes away valuable energy from the group and should not form a part of consultation. All ideas are worth sharing but not all ideas are suitable for every occasion. Further, once a group has made a decision everyone should wholeheartedly support the decision even if they do not agree. If time shows it does not work it can be brought to the group for consultation again. This action, reflection and re-evaluating is all part of the learning process.
- Dominating – in a group process there should not be a 'boss' since this may cause some to overpower or win the favour of the dominant one. Either way it prevents true consultation and will cause problems for the group dynamic.

Appendix H

Table 21 below demonstrates how the model of interprofessional mentoring developed from this study meets the aims of CPD as outlined by SCOPME (1994).

SCOPME's defining factors for CPD	**Model of interprofessional mentoring developed from this study**
Achieve personal and professional growth	One major aim was the personal and professional growth of the new practitioner with the support of a mentor, through regular meetings, teaching and the creation of opportunities for learning.
Keep abreast of and manage clinical, organisational and social changes which affect professional roles in general	Interprofessional mentoring was one of a number of support and learning mechanisms for junior staff, enabling clinical and organisational issues to be examined and understood. Learning about the function and role of other professional groups in clinical areas and within the organisation allowed staff to appreciate their own roles, as well as the impact of others' roles and the organisation on their practice.
Widen, develop and change their own roles and responsibilities	Development of roles and responsibilities needs to take place in the context of the roles and responsibilities of other healthcare professionals. By being mentored by someone from a different professional group, practitioners can understand the role and contributions of other professionals so as to develop their own practice.
Acquire and refine the skills needed for new roles and responsibilities or career	Interprofessional mentoring focuses on raising awareness of the roles and input of healthcare staff in the care of users and in

development	the functioning of the organisation. This awareness contributes to self appraisal of role and career direction.
Locate individual development and learning needs in a team and multiprofessional context	The interview transcript from one mentor (See Appendix F) demonstrates how interprofessional mentoring allowed junior staff to support each other practically with their workload and in turn learn about the stresses and work pressures affecting each of them. The junior staff together were able to identify the stressors of one practitioner and incorporate mechanisms to alleviate them. This approach creates an environment for development and learning to occur and be used in a multiprofessional context.

Table 21. Comparison of model of interprofessional mentoring adapted from this study and SCOPME's defining factors for CDP

List of acronyms

BMA	- British Medical Association
CPD	- Continuing professional development
DoH	- Department of Health
FP	- Foundation programmes
ENB	- English National Board
GMC	- General Medical Council
HO	- House officer (abbreviation for PRHOs)
LLL	- Life-long learning
NMC	- Nursing and Midwifery Council
NP	- Nurse practitioner
PAM	- Professionals allied to medicine
PRHO	- Pre-registration house officer
SCOPME	- Select Committee for Post-graduate Medical and Dental Education
SHO	- Senior house officer
UKCC	- United Kingdom Central Council for nursing, midwifery and health visiting