ACRRM Research Program

Australian Government
Department of Family and Community Services
Office for Women

Australian Federation Of Medical Women

guidelines for developing

continuing professional development (CPD) and mentoring

for rural and remote women doctors

Australian College of Rural & Remote Medicine

AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE

GUIDELINES FOR DEVELOPING CONTINUING PROFESSIONAL DEVELOPMENT (CPD) AND MENTORING FOR RURAL AND REMOTE WOMEN DOCTORS

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CONTENTS

INTRODUCTION

Between September 2004 and May 2005 ACRRM undertook a range of research programs to investigate the particular needs of women doctors in terms of their support and training.

One of the principal findings of the ACRRM 2003 research on support for women doctors identified that there were gaps to fill in terms of the type of mentoring support available for young women doctors in rural practice and also in the range of continuing professional development options tailored specifically for women.

In considering how to approach these challenges, ACRRM was fortunate to attract, in partnership with the Australian Federation of Medical Women, a grant from the Australian Government, Office for Women (OFW) to initiate, or to progress, work in these areas.

The work was undertaken in partnership with a number of organisations and individuals that brought rural experience, educational expertise and input to issues of gender throughout the research and development stages. Their contributions are recognised below.

This document provides two separate resources designed to support the work of women doctors in rural practice:

1. Guidelines for developing CPD for rural and remote women doctors.

This outline is intended, firstly, to highlight the relative lack of attention given by educators to the development of programs that specifically meet the needs of rural women doctors in terms of their design, their delivery or their access.

ACRRM conducted a needs assessment in terms of what women hoped to find in the range of CPD and what would best support their practice needs and their learning styles. Particular incentives and barriers to access were also investigated.

The companion research report: CPD Preferences and Learning Styles of Rural and Remote Female Doctors is available through ACRRM Research Programs.

2. Guidelines for mentoring rural and remote women doctors

These Guidelines were developed and trialled, in part, through collaborative work with ACRRM and the Rural Workforce Agencies of Queensland and Victoria. The OFW grant provided the opportunity to trial and refine the guidelines and to ensure their broad dissemination.

The increasing proportion of young women doctors graduating from medical schools places a particular duty of care on mentors in rural and remote practice. Many women doctors take on the role of mentor on an informal basis and act as a support to other women entering practice.

The aim of the guidelines was to generate a simple aid to mentoring by using a consensus of what was required and expected of the mentoring role and that of mentees. This is intended both to assist existing mentors and to encourage new doctors into the role. Doctors have indicated that, often, a lack of information about what the role might entail inhibits their confidence in volunteering. It is hoped that by providing a basic set of guidelines to generate debate and interest, numbers will increase and activity will become more focused.

This work would have been impossible without the assistance of willing experts and supporters. ACRRM would like to acknowledge the following people and organisations:

- This project was funded by the **Australian Government Office for Women**
- **Australian Federation of Medical Women** for acting as fund holders for this project.

CPD Guidelines

- The OFW Grant Steering Committee for their comments and feedback on these guidelines.
- ACRRM's female doctor membership for their generous contribution to the development of these guidelines, especially those who agreed to be interviewed.
- Providers of CPD for their contribution to the development of these guidelines.

Mentor Guidelines

- OFW Grant Steering Committee for their comments and feedback on these guidelines.
- Dr Lexia Bryant for the initial development of this document.
- Rural Workforce Agency of Victoria and Health Workforce Queensland for their assistance and feedback on the development of these guidelines.
- Dr Jacki Holt for her assistance and feedback on the development of these guidelines.

GUIDING PRINCIPLES

1. CPD activity must be relevant to the practice of rural and remote women doctors.

2. Whilst clinical activity is preferred by the majority of women doctors, less clinically based and non clinical activity is still important.

3. CPD activity should aim to either maintain or update the skills and knowledge of rural and remote women doctors in order for them to provide these services with confidence.

4. CPD activity should be accredited with the appropriate agencies to allow women doctors to claim points for attendance towards maintenance of any professional registrations.

5. When appropriate and possible, CPD activity should have a practical basis, allow for interaction amongst participants and the presenter, be time effective and small group based.

6. Where appropriate, participants in an activity should have similar practice backgrounds and levels of knowledge and skill.

7. A mixture of male and female participants is desirable for most CPD activity, although a greater representation of women within rural and remote CPD events would be beneficial.

8. Presenters should have a non confrontational style, provide opportunities to ask questions and allow participants to determine their own level of involvement.

9. Presenters should be knowledgeable about the topic and be able to communicate this information in a manner that is practical, relevant and user friendly for rural and remote women doctors.

10. Mutual respect for the knowledge, skills and experiences of the presenter and participants must be demonstrated.

11. The design and delivery of CPD for rural and remote women doctors must be flexible in terms of timing, location, provision of support services and delivery mechanisms.

12. The promotion of CPD activity must be balanced so no woman doctor is discouraged from participating for whatever reason and this promotion must provide plenty of advance notice before the activity date.

13. Financial grants or subsidies to reduce the associated costs to attend an activity, especially if a member of the education provider, should be offered if possible.

14. Acknowledgement that the issues and preferences of rural and remote women doctors are becoming, or are, as relevant to their male counterparts.

15. All education providers should be acknowledged and appreciated for their contributions to the design and delivery of CPD and their efforts at meeting the specific needs of their users and members.

GUIDELINES FOR DEVELOPING CONTINUING PROFESSIONAL DEVELOPMENT (CPD) FOR RURAL AND REMOTE WOMEN DOCTORS

1. INTRODUCTION

It is evident from the medical workforce literature that an increasing proportion of doctors graduating from medical schools and entering training programs are women. This will have a significant impact on the composition of the future medical workforce, particularly with rural and remote communities where the recruitment and retention of doctors may be difficult.

One method of supporting women doctors within rural and remote practice is the provision of and access to Continuing Professional Development (CPD) that is appropriate, accessible and affordable. Through the identification of the learning styles and preferences of women doctors as well as the barriers that impede their access to CPD, education providers could design and deliver education that reflects these preferences as well as provide better access and opportunities to CPD.

Whilst it is important that efforts be made to address the preferences and barriers of rural and remote women doctors, these must be balanced against the demands and limitations faced by providers of educational activity and consideration given as to how they impact on their ability to provide appropriate CPD. By giving consideration to the preferences and limitations of both education providers and women doctors, the provision of CPD activity that is feasible, appropriate and cost effective for all rural and remote doctors, regardless of gender should be achieved.

2. SUMMARY

The following principles should be considered as a guide within the design and delivery of CPD for rural and remote women doctors:

1. CPD activity must be relevant to the practice of rural and remote women doctors.

2. Whilst clinical activity is preferred by the majority of women doctors, less clinically based and non clinical activity is still important.

3. CPD activity should aim to either maintain or update the skills and knowledge of rural and remote women doctors in order for them to provide these services with confidence.

4. CPD activity should be accredited with the appropriate agencies to allow women doctors to claim points for attendance towards maintenance of any professional registrations.

5. When appropriate and possible, CPD activity should have a practical basis, allow for interaction amongst participants and the presenter, be time effective and small group based.

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14. Acknowledgement that the issues and preferences of rural and remote women doctors are becoming, or are, as relevant to their male counterparts.

15. All education providers should be acknowledged and appreciated for their contributions to the design and delivery of CPD and their efforts at meeting the specific needs of their users and members.

3. BACKGROUND

This section enlarges on some of the issues and provides some context to the recommendations as they emerged from the research findings. The material is aimed at informing education providers about some of the requirements identified by women doctors that would enable them to attend CPD more often and for the content and format of the programs to be appropriate for their professional needs and learning styles.

3.1 Content

The topic area and information presented and the potential outcomes of attending an activity will largely determine a doctor's level of interest in participating. For women doctors, there are two key factors that influence this level of interest:

- relevance to their every day practice and
- outcomes in terms of the maintenance or updating of their skills and professional registrations.

Relevance to Practice

Rural and remote women doctors practice in a broad range of fields and disciplines ranging from general practice to advanced procedural practice. This breadth of practice is reflected in a diverse range of content that doctors can select as part of their continuing professional development. In response to this plethora of choice, doctors are becoming increasingly more selective in their selection of CPD and are basing their decisions on the relevance of the activity's content to their everyday practice.

Principal choices involve programs with content regularly encountered within practice or of special interest. For example, a large proportion of the services provided by rural and remote female doctors are women's health and mental health consultations and programs that target these areas would have a high relevance, and therefore be of interest to female doctors.

However, just because an area of medicine is not regularly encountered within a doctor's work environment does not diminish its interest. For many doctors, it is important to maintain and regularly refresh their knowledge and skills in topic areas that are not routine, but are nonetheless essential to quality care when they do occur. For example, maintenance of Emergency Medicine skills for doctors on call after hours.

In keeping with this notion of relevance, the majority of rural and remote women doctors demonstrate a preference for clinical topic areas in relation to those with a less or non clinical focus but this does not negate the importance of non clinically based activity within particular sub groups of women doctors.

Maintenance / Updating of Skills and Professional Registrations

Patterns of choice highlight the importance to doctors of maintaining their skill sets within fields of medicine considered to be both relevant and essential to their practice. It therefore makes sense that, when making decisions about CPD activity, the immediate outcomes and benefits perceived as a result of attending the activity will be a determining factor. For

many doctors, the opportunity to maintain and / or update their skills and knowledge and meet profession regulatory requirements will directly influence their decisions to access CPD. The need to maintain multiple skills and credentials, especially for proceduralists, is a major determinant of choice of CPD in rural and remote medicine.

Activities that allow doctors to keep up to date with the latest developments whilst refreshing those competencies already held within their areas of practice will give doctors increased confidence in providing the highest quality, most up to date care to their patients. This should also result in evidence of improved patient and / or healthcare outcomes.

In meeting the regulatory requirements of various medical and professional associations, most doctors must undertake and complete educational activity that can be accredited towards this goal. These doctors are likely to select those activities that will assist them to meet their specific requirements and / or have been accredited by the relevant professional association to attain their continued registration. Therefore education providers should aim to provide accredited CPD activity whenever possible.

3.2 Learning Environment

The environment in which educational activity is held is a key determinant in the design and provision of CPD as well as in the achievement of the activity's learning objectives and outcomes.

For women doctors, two areas have been identified as having a determining influence on this:

- structure and format of an activity, and
- characteristics of the presenter.

Format and Structure

The content or topic of an activity has much to do with how an activity is structured and ultimately, its effectiveness in the delivery of learning outcomes. Whilst there is a range of formats and structures available, most women doctors indicate a preference for activity to be practical, interactive, time effective and small group based.

In keeping with the notion of relevance to the practice of rural and remote medicine, women doctors where possible will select activity that utilises a practical and hands on approach, particularly for content that is skill driven. This practical basis allows for active demonstration of the knowledge and skills being learnt and the opportunity to both practice and consolidate this information, especially if not used or accessed regularly within every day practice.

Small group formats are also favoured by women doctors. This type of format provides greater opportunity and encourages interaction between the presenter and group participants as this assists in the transfer of knowledge and information. Opportunities for interaction amongst group members themselves can also enhance the learning environment for women doctors.

For many women doctors, learning within this small group format is enhanced if other participants within the group are professional colleagues from within the local area and are known to other participants. The shared experiences of practicing in rural and remote medicine provide a sense of common understanding of the every day pressures faced by doctors and an opportunity to network, support and debrief without fear of their experiences being de-valued or dismissed.

Sharing CPD with local peers in most cases also results in participants having similar levels of knowledge and skill, allowing for activity content to be targeted at the appropriate level. In most instances, women doctors enjoy CPD programs that jointly include male and female doctors, unless the activity is specifically targeting women doctors. However, a greater representation of women at some CPD activity would make some female doctors more comfortable within these learning environments.

Activity that is time-efficient is also preferred by women doctors but care must be taken to ensure that the quality of the activity does not suffer. Whilst condensed activity that can be completed quickly is favoured by many women doctors, not all skills and knowledge can be effectively learnt through these means. Therefore every activity must allow sufficient time for its content to be learnt, understood and if necessary, practiced and consolidated. To not do so undermines the confidence and comfort level of doctors incorporating these new skills and knowledge into their practice.

Presenter Characteristics

A presenter's style, attitude, knowledge and ability to communicate effectively are just as important in enhancing the learning experience of participants and effectively achieving an activity's learning objectives.

The opportunity for interaction between presenter and participants is an important aspect in the transfer of information. To be most effective, this interaction should be tempered with mutual respect for the skills, knowledge and experiences of both the presenter and participants.

The adoption of a non-confrontational style of teaching and / or presenting is also favoured by women doctors. Presenters who provide opportunities to ask questions without fear of being embarrassed and allow participants to determine their own level of involvement in an activity enhances the environment and consequently the learning of women doctors. Those presenters who place participants under pressure or draw attention to them in front of others, through direct questioning or the performance of an action that makes the participant uncomfortable, will do little to encourage women doctors to learn effectively and as a result will not achieve the desired activity outcomes.

Relevance is an important consideration. To best achieve the learning objectives of an activity, presenters must be able to deliver information that is relevant, practical and user friendly for participants. A presenter may be an expert in their field, but if they are unable to make it relevant or practical within the practice context of participants or do not communicate this information well, it is unlikely that this knowledge will be transferred and consequently put into practice.

For similar reasons, women doctors generally do not have a preference for presenters of a specific gender, unless an activity specifically requires this. As long as the presenter had considerable knowledge in the area, could make it relevant to either the clinical or rural and remote medical context and communicated well, their gender was not of concern.

3.3 Access

Whilst women doctors do take part in CPD activities, many would like the opportunity to access more education than at present.

The reasons for this reduced capacity to participate stem from two primary sources:

- women doctors are often working to achieve balance between their professional and personal responsibilities, and
- limits set by the financial impost and other associated costs of attending and participating in CPD.

Promotion of CPD

The promotion of a CPD activity as family friendly would encourage those women doctors with children and a partner to attend, but this may also have the opposite effect. For women doctors who are single or have no children, the promotion of an event as family friendly may, in some instances, discourage them to attend as they view the event as not relevant to them. Therefore, the promotion of CPD activity should be balanced and reflect the needs of all potential women doctor attendees.

Delivery

Flexibility within the design and delivery of CPD activity would benefit many rural and remote women doctors and this flexibility can take several different forms. For instance, the provision of CPD activity at suitable times (eg of an evening or a weekend) would remove some of the difficulties women doctors face in taking time away from work and finding appropriate locum coverage.

The increased provision of CPD activity within local areas would also assist some rural and remote women doctors in accessing appropriate activities by reducing the amount of time they had to take off from work whilst allowing them to remain within the local area. However, appropriate CPD activity of an evening or weekend might not suit those women doctors who would prefer to spend this time with their family or are unable to attend as they are on call either after hours or over weekends. The provision of local CPD activity would reduce the amount of time women doctors would have to spend away from their families. It would also allow those doctors who are on call to attend an activity but still be available to respond to emergencies, although this may not be an ideal arrangement.

The flexibility of CPD activity is not limited to simply when and where it is delivered. To be considered truly flexible, activity also needs to be delivered through a wide range of media to best meet the educational needs and preferences of all potential users. This could be directly within small learning groups of local doctors, via satellite broadcast or the internet for doctors in remote locations or who prefer to stay at home of an evening with their

families or a combination of module notes and readings for those not technologically inclined. The more ways an activity can be effectively delivered the easier it is and the more likely it is to be accessed.

Family support

For many women doctors, however, there will be instances in which family members (children and / or spouse / partner) would like to, or have little option but to accompany them to an activity. This is especially relevant if an event is being held over a couple of days or weekend, is some distance away from home or there is a lack of support options (eg suitable childcare, no partner) within their local area. For these doctors, the promotion of CPD activity as family friendly would encourage them to attend.

The provision of appropriate activity programs for both male and female partners / spouses that ran concurrently with the educational program could encourage women doctors and their partners / spouses to attend. Child minding services or activity programs for children provided at or close to where CPD activity was being held could also provide women doctors with children the opportunity to access and participate, although the legal and other difficulties inherent in this are acknowledged.

Balancing Professional and Personal Responsibilities

A number of professional and personal / family issues impact upon the ability of women doctors to participate in CPD. However, the degree to which these issues impact upon women doctors will vary and change over the progression of both their professional and personal lives. It is therefore important that CPD be flexible in both its delivery and design to meet the specific needs of all rural and remote women doctors.

Trying to meet regulatory requirements through participation in appropriate CPD activity is difficult for many rural and remote women doctors, especially when also trying to balance the responsibilities of both their professional and personal lives. From the ability to schedule an appropriate amount of time away from work and a lack of appropriate locum coverage, to time spent away from family members and a lack of suitable childcare, these factors prevent many women doctors participating in relevant CPD activity.

Financial Imposts and Implications

Regardless of the degree of flexibility that some activities provide, it is almost certain that many rural and remote women doctors will have to attend CPD activity outside of their local area. The result of this is significant financial cost, especially if extensive travel and accommodation needs are required. This cost is further exacerbated if the doctor misses out on income due to not working, has to pay for a locum to provide coverage whilst they are away or if it is necessary for, or family members wish to accompany them to these events.

The availability of funding, for instance in the form of a educational grant, to assist rural and remote women doctors to attend educational activity outside their local area would do much to alleviate this financial burden. This funding could be used to reduce the costs associated with the activity (eg registration, travel or accommodation expenses) or other related expenses such as the costs of employing a locum to provide coverage, or

childcare. For those education providers with a membership basis, reduced or subsidised rates could be offered to members for registration, accommodation and travel.

4. WHAT CAN EDUCATION PROVIDERS DO?

In fairness, many education providers already take into consideration the preferences of women doctors within their current education delivery and provide some or most of these services to both male and female doctors. Education providers recognise the specific difficulties faced by women doctors in accessing CPD activity and also acknowledge the principle of providing equity of access to all, based on individual need rather than gender. However, this is not seen by women doctors as the norm in terms of education provision at this time.

The ACRRM Research study recognised that education providers have pressures on funding and resources and also have to maintain services to the majority of education users. However, the research does highlight the need for an increasing change of emphasis to program design and delivery to blend with workforce changes and to changes in practice profile and lifestyle expectations of young doctors of both genders.

Just as rural and remote women doctors strive to balance the demands placed on their time, abilities and resources, so too do education providers in terms of their ability to design and deliver activity that is appropriate and meets educational need. Factors such as demand from users or a membership base, their geographical spread and numbers, whether an activity has been identified as a priority or area of learning need, access to appropriate resources and the cost to deliver, all determine if and how an educational activity will be designed, promoted and delivered.

Whilst the adoption of all the strategies and options for the design and delivery of CPD outlined in this document would greatly enhance the opportunities and ability of rural and remote women doctors to participate, it is acknowledged that this is an ideal. In reality however, the extent to which this ideal can be realised is a question of feasibility. Ultimately, any efforts made by education providers to try to address these issues and preferences, to increase the opportunities for rural and remote women doctors to access CPD, must be acknowledged and appreciated.

GUIDELINES FOR MENTORING RURAL AND REMOTE WOMEN DOCTORS

Mentoring programs need to be tailored to the particular target group of mentees and in a nation as big as Australia, with a multitude of sustainable models of rural and remote medical practice, we need to be inclusive and flexible.

Definition of mentoring

Mentoring refers to an ongoing supportive relationship between the learner and an experienced rural practitioner for the duration of the vocational training. It is the process by which the mentor acts as an experienced guide, advisor, trusted counsellor or advocate to the learner. The mentor assumes responsibility for helping the mentee to learn and to achieve their potential.

Definition of a Mentor

A mentor is an experienced, skilled and knowledgeable female member of the medical profession. They are good listeners and respecters of confidentiality and most likely they have already acted in the mentor role with students, registrars in their practices, other female colleagues and members of their communities.

Definition of a Mentee

A mentee could be a female doctor new to rural practice (including international medical graduates), a doctor in training for rural practice, or an experienced female doctor who may be isolated or lacking a support system.

1. INTRODUCTION

It is evident that female doctors in rural towns require particular forms of support. Those most likely to require this are young doctors new to rural practice, vocational training registrars and some experienced members of the profession.

Mentoring develops people and as a result, both partners in a mentoring relationship can expect to increase their skills as an outcome of their participation. Successful mentoring requires active participation in the relationship with both mentor and mentee taking equal responsibility for its success. It also requires collegial and institutional support.

Whilst the focus of this document is on women doctors, it is important to acknowledge that the benefits of mentoring can also be equally applicable and relevant to the support needs of male doctors in similar circumstances.

2. BACKGROUND

Previously, rural training, rural workforce and rural medicine in Australia were grossly neglected and many of the rural communities of Australia were deprived of quality medical care. An enormous amount of work has been and is being done to address this issue. The Australian College of Rural and Remote Medicine (ACRRM), Rural Workforce Agencies and the Rural Doctors Association of Australia (RDAA) have been leading participants in achievements to date.

However, it has been well documented and recognised that many rural communities remain underserved of female medical practitioners, and this continues to be a particular need throughout rural and remote Australia. The lack of rural female medical practitioners remains a critical workforce issue.

Sixty-one percent of the GP registrars in the Australian General Practice Training Program (AGPTP) are women and in the current training climate more than 90% of supervisors are men. Many of the female doctors entering rural and remote practice, including registrars, female doctors from other pathways, and some experienced members of the profession are working in rural towns that have had little to no experience of women as doctors.

These female medical graduates have come through their undergraduate training and hospital years with little exposure to significant female medical role models. Many teaching practices and female mentors, as well as the female rural registrars and other experienced female members of the profession would benefit from systematic support systems that consider their needs as women, as well as rural doctors.

It was against this background that the ACRRM Guidelines for Mentoring Rural and Remote Women Doctors was developed. To encourage more women doctors into rural and remote Australia, there is a need to provide the best training experience possible for rural and remote registrars and other rural and remote women doctors in order to create a culture where they are valued for their professionalism, their style of practice and their multiple roles as mothers and family carers.

3. RATIONALE

These guidelines aim to provide rural and remote women registrars and other women doctors with the opportunity to access the advice, knowledge and support of experienced rural and remote women doctors. Through the provision of this support, these doctors and registrars will experience their time in rural practice positively, encouraging them to continue their practice in a rural or remote location. It also aims to provide support, advice and training from experienced rural and remote women doctors in all aspects of mentoring.

Mentoring Models

Both mentors and mentees should be approached, recruited and matched by the organisation providing the mentoring program. Geographical location should determine the matching of mentors with mentees, although interest in a particular or speciality area may also be taken into consideration.

The geographical location, time constraints and work / study / personal commitments of participants may also determine to a large extent the model adopted to deliver the mentoring program. Whilst face to face meetings would be optimal, this may not be either cost or time effective in rural and remote medical practice. Mentoring via electronic media or teleconference may provide a suitable alternative.

Supports and Resources

Mentor Coordinators should be appointed to oversee the administration and implementation of the mentoring program. They should be responsible for the orientation of both mentors and mentees, provide resources as required and facilitate a support group for mentors within the program.

An experienced rural and / or remote medical practitioner should be available to the Mentor Coordinator, mentors and mentees to provide advice, support and counselling (if appropriate) in regard to significant issues or problems that may arise. It is also important to promote information and contact details for additional support services that participants can either be referred to or can access themselves.

Mentor training should be provided to all participants in the program. The nature, format and delivery of this training are highly dependent upon the geographical spread of participants and the availability of participants to attend.

Both mentors and mentees in the program will be eligible to claim ACRRM PDP points (1 point per hour) for their participation.

The Mentoring Relationship

Within literature, the earliest reference to the term "mentor" was in Homer's "The Odyssey". In this Greek myth, King Odysseus calls upon a neighbour / subject named Mentor to guide and educate his son Telemachus on his journey through life. As a consequence, the term mentor has become synonymous with one who is a wise teacher, guide and friend.

In modern mentoring relationships, which can be short or long term, a mentor provides a mentee with wide-ranging support and guidance. In the ideal situation the relationship evolves as the mentee matures to eventually become a peer. However, some short term relationships contribute increments on the way to achieving that maturity and are still valuable relationships. Many of us can look back over our careers and life's journey and identify several mentors at different stages.

4. ROLES AND RESPONSIBILTIES OF MENTORS

The mentoring relationship should be focused on the specific needs and goals of the mentee whilst providing the mentor with a sense of achievement and pride. Mentors should be a confidante and provide support, encouragement and other assistance as required.

Feedback from rural doctors that have acted as mentors in the past indicates that there is much to be gained from the experience, including an opportunity for self-reflection, learning new skills and looking at things from the perspective of a younger colleague.

The multitude of roles of a mentor is well established. Many rural and remote women doctors are familiar with these roles as they work in their practices and reflect on their experience as medical students, registrars in training and competent rural medical practitioners who are members of their communities. Whilst it is acknowledged that many aspects of being a mentor overlap, it is useful to have an understanding of the following basic elements:

- Confidentiality
- Motivation
- Advising
- Listening
- Guidance
- Role Modelling
- Accessibility
- Support

Confidentiality

A mentor is always required to maintain confidentiality, empower the mentee and support their decisions. Whilst a mentor may feel challenged by the issues being faced by their mentee and be tempted to adopt the role of an advocate – this may not be in the best interests of the mentee who needs to develop the skills and confidence to deal with the situation.

As women doctors, we all have stories about the lack of the "tap on the shoulder", the difficult consultant, the lack of respect for women's ways of working, but the confidentiality of the relationship may require the mentor to stand back from the advocacy role. Above all, confidentiality must be maintained because it is the most respectful role the mentor can model for the mentee. Support for mentors faced with this situation is vital. The mentor's role can and should be clearly defined and made explicit.

Listening

Active listening in the mentor / mentee relationship means that discussion needs to be open and mutually respectful. There is a need to recognise the differences when a mentee wants to find a sounding board and when they would like to receive active feedback and suggestions about possible interventions. It is vital that mentors acknowledge this distinction through active listening and confirmation of what the mentee requires of both the mentor and the mentoring relationship at that time.

Accessibility

Agreement on a regular contact time and the adherence of both parties to this agreement provides the foundation for a mutually beneficial mentoring partnership. The time and methods by which this regular contact occurs are varied and will be dependent upon a range of factors including time constraints or geographical location. Intermittent contact between these times may also be beneficial if required.

It is likely that this contact may be brief when things are going well for the mentee and occasionally there may be a need for extended contact time. A regular contact time will create an opportunity to decide whether extra contact would be beneficial and whether or not this is urgent. If urgent, a mutually suitable time needs to be set aside as soon as is convenient.

Whilst it would be desirable for one contact each year to be held in person, it is recognised that this may not be feasible.

Motivation

It is important to motivate mentees towards the achievement of their goals and to be aware of resources that can be offered in support of this. From the outset, communication with the mentee about their goals needs to be established and recorded. As the mentoring relationship progresses, both mentor and mentee can review their progress towards goals and modify them as the mentee progresses and matures in their role as a rural medical practitioner.

Guidance/ support/ advising

A mentor is often a person with seniority, experience and standing in the community whilst a mentee often has little experience or knowledge of the community, the medical profession, or the rural / remote community that they have entered. Within either of these communities, the ability to provide guidance, support, advice and counsel may sometimes be the most important factor in enhancing the skills of a mentee through their experience of a new and unfamiliar environment.

Role Modelling

A mentor's own virtues, achievements, professionalism and lifestyle enable them to serve as an exemplar to which a mentee can seek to emulate.

5. ROLES AND RESPONSIBILITES OF THE MENTEE

Successful mentoring requires active participation in the relationship with both mentor and mentee taking equal responsibility for its success. The following aspects of the mentoring role are just as applicable to mentees:

Confidentiality

- Maintain confidentiality within the partnership

Listening

- Actively listen
- Ensure all aspects of discussion are open and mutually respectful

Accessibility

- Commit to a regular and suitable time

Role Modelling

- Be aware of how a mentor represents a model of sustainable rural medical practice for women

6. CONCLUSIONS

ACRRM is proud to be offering these guidelines in support of the provision of mentoring opportunities to both current and future rural and remote women doctors in Australia. It is hoped that these guidelines will assist in the transfer of invaluable and sustainable knowledge and skills from experienced rural and remote women doctors to those who are yet to experience both the benefits and challenges of providing medical care within a rural and remote environment.

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