*The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.*

# DEVELOPING MENTORS FOR COMMUNITY SERVICE DOCTORS

An experience from Northern KwaZuluNatal

## Introduction

As is well known, 1999 saw the introduction of community service for newly qualified doctors in South Africa. Many were allocated to rural hospitals around the country. This was done with very little preparation – either for the community service doctors themselves or for the receiving institutions, both in terms of physical arrangements and in terms of support. Many of these doctors had never even visited a rural area before.

The National Department of Health delegated the responsibility for implementing the programme and ensuring its running to the nine Provincial Departments of Health. In the KwaZuluNatal province, decisions regarding where to send doctors had largely been made on the basis of the availability of posts rather than the presence of senior doctors to support them. No plan was made to support the community service doctors in their positions or to assist those who would be given responsibility for supervising them.

## The process

For these reasons, concerned senior doctors in rural district hospitals in northern KwaZuluNatal Province, to which community service doctors (CSDs) were allocated, decided to be proactive in designating mentors to support them. A mentor was thus chosen in each of these hospitals. A meeting was held in November 1998 to prepare these mentors for the arrival of the community service doctors and to learn together about mentoring. Doctors from 13 hospitals in northern KwaZuluNatal were invited. (A similar process took place parallel to this at 2 other sites in central and southern KwaZuluNatal.)

The first meeting decided that there was a need to support each other in the process of mentoring these conscripts and to meet regularly to discuss issues and assist each other. This northern group met an additional 3 times over the subsequent year, the final meeting being a review of the year and planning for the next cohort on the basis of this. They continued to meet for some time thereafter. At the same time, meetings of community service doctors themselves were also facilitated. The Rural Health Initiative of the South African Academy of Family Practice/Primary Care sponsored the meetings, held at a hotel in a central venue. Although the numbers varied, a solid group of 10 to 15 senior doctors from these northern rural hospitals met on each occasion.

What was unique about this process is that it was driven by the affected hospitals themselves, without any support from government – in fact, submissions made to the Provincial Department of Health by this group were completely ignored – arising out of a desire to make the community service programme work well in their institutions because they wanted to influence young doctors positively in terms of the rural health experience.

The aim of sharing the process and the issues discussed is to pass on some of the lessons learnt which I believe can help any programme that aims to support community service professionals or new doctors in rural areas.

## The what and why of mentoring

The first question the group addressed was why should we be mentors?

The following reasons were proposed:

1. We believe in people; without human resources we are sunk
2. We believe in what we are doing as rural doctors.
3. We want to practice good medicine.
4. Self-interest: we were concerned about how we would manage with this group.
5. To prevent disaster: we wanted to be proactive.
6. To ensure positive experiences, so that people will consider rural medicine as a career.

These motives sustained the group through the year, being a good mix of idealism and pragmatism. What then, we asked ourselves, is a mentor?

Many definitions could be written. In order to look at this we discussed some practical, possible scenarios drawn from experience, in small groups, reviewing how we would handle difficulties, which might arise. In the light of this, we then defined mentoring to include the following:

- being available
- assisting learning
- learning with others i.e. to be involved in 2 way learning
- acting as a signpost, giving direction
- supporting, not just clinically but also and especially emotionally.
- being a role model, in medical, psychological, spiritual, ethical/moral arenas
- walking with someone, being a friend
- facilitating personal development
- teaching skills
- giving confidence to use skills: developing independence
- allowing mistakes and helping to deal with mistakes
- inspiring people
- creating a positive atmosphere
- helping adjustment to a different situation

It should be a voluntary activity!

The group felt that, just as we need to see our patients in terms of the clinical, individual and contextual spheres, so as mentors we need to work in the pro-fessional, personal, and relational spheres.

The way that doctors adjust to new working situations is often akin to culture shock.[1] We thus looked at the phases of culture shock, as a model for how the new community service doctors might adjust to their new work situations. The idea was that recognising these phases could help us in our own reactions to the doctors experiencing them. The typical phases are:

1 Fascination
2. Irritation
3. Depression
4. Adjustment

It was interesting to hear during the year how community service doctors certainly went through these phases, but all at different rates, ending at different points. It was good to remind each other of this, as mentors, when anyone in the group felt exasperated!

## Attitudes towards the programme

During the year we also had a chance to evaluate the community service programme from our own perspective

as mentors, because it was then such a new programme. Although many negative points were raised, there were more positive points raised than expected which left us feeling encouraged about the programme. Though they do not touch directly on mentoring, I mention these briefly, because they are critical to the process, and highlight issues which must be taken into consideration.

Some of the positive points raised about the programme were the following:

1. It stimulates thinking and learning in other doctors
2. People enjoyed themselves unexpectedly
3. It feels good as mentors to know how to advise others clinically
4. Boundaries have to be negotiated.
5. Pushed to do what we are too scared to do, we cope well (not in terms of teaching skills, but in terms of our own responsibility as mentors.)
6. There are now more doctors
7. There is a more reasonable call duty roster.
8. We are less tired and stressed
9. There are fewer arguments
10. Some hospitals are now getting South African input and teaching (referring to hospitals previously staffed only by foreign doctors.)
11. Young doctors are getting exposure to and an understanding of rural health problems
12. More isiZulu speakers lead to better understanding of patients (referring to some of the community service doctors who were first language Zulu speakers.)

Some of the more negative points raised were the following:

1. It is difficult to teach a programme where there is lack of interest.
2. Groups of community service doctors can influence each other negatively
3. Some community service doctors are too demanding
4. Complaints occur about the lack of laboratory facilities and sophisticated back-up. (This was felt to indicate a failure of training to prepare these graduates for the realities of rural medical practice.)
5. Some senior doctors feel they are looked down on as failures.
6. Some seniors feel resentful about sharing their experience and knowledge, which was gained at great cost.
7. It is difficult to accept changes.
8. Community service doctors are often insufficiently aware or concerned about the social situation of their patients.
9. Poor communication and false expectations are problems.
10. Roles need to be clarified.

Many of these were teething problems related to the first year of the programme, about which we all had a lot of angst.

## Dealing with mistakes

As mentioned above, one of the roles of mentors was seen to be helping others deal with mistakes. In order to facilitate that, in one of our meetings we focussed on the issue of mistakes and how we deal with our own mistakes. Some of the ideas raised in terms of how to deal with our mistakes (and thus the mistakes of those we are mentoring) included the following:

1. Create an atmosphere of sharing mistakes
2. Encourage an open approach
3. Admit, talk about and learn from mistakes.
4. Recognise feelings around mistakes.
5. Carefully look at why the mistake happened.
6. Ensure peer group discussion.
7. Tell the patient if it is to his or her benefit.
8. Remember: If you do not want to make a mistake, stay in bed!

## Issues of training

The possibility of a programme to train trainers in the province was raised, as part of a proposed WONCA-World Bank initiative. Thus, we discussed ideas for what might be included in this.

The main proposals were:

1. Regular workshops for training
2. Regular mortality meetings/post mortem reviews
3. Management skills training
4. Practical experience to allow opportunity for skills development
5. Input from Tropical health specialists
6. Visits from specialists from regional hospitals
7. Rotation of registrars from tertiary centres through rural hospitals.

It is interesting that this list, drawn up in the middle of the year, is quite different from the list of mentoring skills made at the start of the process, and perhaps reflects the feeling, at that point in the programme at least, that the issues which dominated were practical, clinical ones.

At the same time, though, the fear of stress and burnout was raised as a major issue by the mentors' group and one meeting was almost entirely devoted to that issue.

## What did we learn?

At the end of the year, the group looked back and evaluated what we had learnt about mentoring through the year. Certainly, it was a growing experience for everyone, even though it took some people closer to the burnout line!

Lessons included the following:

- Communication is essential
- Have the courage to tackle difficulties as they arise.
- Give positive feedback constantly.
- Orientation is vital. (Some hospitals previously had no orientation process.)
- New doctors should write down their expectations, as part of orientation.
- Aim to develop the medical team together, and do not focus only on new doctors.
- Be aware of seniors taking advantage of community service doctors, yet make them feel needed, i.e. give responsibility balanced with support.
- Treat people as individuals and make an effort to integrate people as individuals.
- The Medical Superintendent (the line manager) is not an effective mentor.
- Remember that people change and adjust. Do not write them off too quickly!
- A community service doctor is just another doctor.
- Attitudes will also change over the years.
- DO NOT EXPECT THINGS TO BE THE SAME NEXT YEAR.

## Conclusion

The process of meeting as mentors worked because it was driven by the participants. The sessions focussed on practical issues and input was based on the needs within the group. Outside resources were not used: it was a process of learning together.

For this to be replicated would require similar commitment on the part of other groups, otherwise there would need to be greater external input. Nevertheless, I believe the process can serve as a model for other programmes aimed at developing mentors.

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## Reference

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