Mentoring, performance and the GDC

In the second of three articles, **Mabel Saw** and **Janine Brooks MBE** look at mentoring and how it brings benefits to dentistry, to patients and to those who work within it

Introduction

As a profession, we all aim to deliver safe patient care. The Francis Report[1] highlighted how safe patient care should be at the forefront of any healthcare profession. In dentistry, we are all familiar with the General Dental Council (GDC) which serves to protect the public and puts safe patient care at the heart of dentistry.

Nevertheless, we are all individuals and only human. Try as we might, our performance can sometimes dip as we face multiple demands on our time and energy. Very occasionally, this can result in patient complaints or even a GDC hearing. GDC investigations and hearings often take a while to resolve, with some complex cases lasting more than two years.[2] This is stressful to the individual and distracts us from our daily patients.

Performance challenges and mentoring

With an average working life of 30-40 years and increasingly demanding dentistry, it is reasonable to expect that most of us are likely to face a GDC investigation or hearing at least once in our practising life.[3] This can be a bewildering and overwhelming experience. Mentors are often recommended to work with registrants as part of the remediation process and act as trusted guides through what is often a difficult journey. Mentors are also instrumental in helping registrants reflect on their actions, behaviour and the issues which have led to such complaints in the first place. They support and work with the registrant to formulate an appropriate Personal Development Plan (PDP), to deepen insight and self-awareness and to embed crucial lessons that have been learnt so that

similar errors are much less likely to happen in the future. Insight is the key to breaking a cycle of repeating error. It is the major characteristic that GDC panels look for.

PDPs and mentoring

Although one of the GDC's roles is to act when there are concerns about a dentist's performance, the public expects it to have a wider role to address any risk factors that could lead to patient complaints in the first place.[4] After all, the former is being reactive and puts the profession on the back foot, whilst the latter is proactive and more effective in tackling root causes that underpin complaints and poor performance.

As an aid to this process, the GDC requires all dental registrants to have PDPs and to have completed enhanced Continual Professional Development (eCPD) as part of the *Moving Upstream Report*,[5] thus keeping safe patient care at its and the profession's core. This is a significant shift towards a more reflective style which engages our higher thinking.

PDPs help us plan our CPD, supporting us in our development towards our goals. The GDC sets out four development domains: communication, leadership and management, clinical skills and professional skills.

Consequently, the GDC recognises that a good dentist goes beyond clinical skills and encompasses broader fields of leadership, management skills, communication skills and professionalism. Dentistry is so much more than hands-on clinical interventions; any patient will tell you that. Any principal running a practice will tell you that.

Yet many dentists continue to pursue clinical skills almost at the expense of the remaining three domains. Likewise, course providers continue to promote the latest expensive equipment and techniques, perhaps in the mistaken belief that a successful practice only needs fancy equipment and clinical skills. In fact, the reverse is true.

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Whilst I do not underestimate the importance of our clinical skills as this ultimately sets us apart as a profession, there is danger that we are trivialising non-clinical skills. The GDC considers leadership, management, communication and professionalism as equally valuable as clinical skills. This does not mean that we should belittle our clinical skills; instead, this means that leadership, management, communication and professionalism should be elevated and treated as *equally important* as clinical skills. We have only to look at some of the issues raised at GDC hearings to appreciate that patient complaints often arise from poor communication and lack of professionalism.[2] The nature of dentistry means that patients often cannot tell if we are doing good clinical work or not; what they can judge is how we interact with them and with the wider team. That is why good chairside manners matter, building rapport and trust matter, making patients partners in their own care matters. And this is not something that is 'nice to have' that we can delegate to other members of the team whilst we focus on the drilling. This matters even more so because patients are often vulnerable when they attend, either because they are in pain, feeling anxious, lacking knowledge or a combination of all these factors. Being a great dental professional means you can incorporate all four domains in your day-to-day practice with every patient.

eCPD and PDPs are intended to be much more targeted to our individual field of practice. PDPs work on a template of Plan, Do, Reflect and Record, similar to the GROW model first developed by Sir John Whitmore.[6] This model is based on identifying:

- → the **G**oal which we would like to achieve
- → assessing the current **R**eality we are in now
- → reviewing our **O**ptions for actions
- → before deciding **W**hen we carry out the action.

Although originally developed for the sporting industry, this model has been widely adopted across other corporate sectors.

PDPs require some thought when planning our CPD. If the process is to be worthwhile and beneficial, it requires us to think about what we are trying to achieve within an appropriate timeframe. This might seem straightforward initially but if the GDC is encouraging reflective practice then we need to learn to be more reflective. This goes beyond thinking about our goals and delves deeper into our emotions and values. Some dentists might struggle with this concept as we are masters at hiding our emotions from our patients, adept at putting on our professional persona, having learnt to suppress our feelings whilst still at dental school.

Meaningful reflection may not come naturally or easily to many dentists as we tend to be activist/pragmatist rather than theorists;[7] many find reflection rather trifling and frivolous.

This is probably a good point to think about learning styles and what they can tell us about reflection. Peter Honey and Alan Mumford developed a model using four different learning styles or ways of learning – *Activist, Reflector, Theorist and Pragmatist*.[8] Their work builds on that of Kolb.[9] Most people have a preference for one or two styles, but are comfortable using others. The people who can really be effective learners are able to learn in all four styles. Once a person

knows what their preference is and how the other styles work, they can work on using the other styles. In broad terms activists and pragmatists tend to be 'doers' whilst theorists and reflectors tend to be 'thinkers'.

The styles are guides and preferences to the ways people like to learn. Preferences will be strengths, whereas the other styles will need more work on the part of the individual. However, a person can train themselves to develop the styles they are less strong on – the challenges. Learning preferences are not fixed; everyone can work on their least well-developed preferences.

Learning styles point the way to how a person likes to learn. Reflection is a powerful learning tool. We learn from our own experience of what works and what doesn't. Research undertaken by Osbourne *et al*[7] into learning styles of surgeons and physicians showed interesting differences in the four learning styles, with surgeons showing a natural tendency to be activists and pragmatists, as shown in Table 1. As dentists are surgeons, it would not be too much of a leap to compare the learning styles as being similar. You could find out more about your own preferences by undertaking the Honey and Mumford questionnaire which is on-line. You could work with a mentor to get the best out of that knowledge.

Mentors help us peel away our professional persona in a non-judgmental, supportive way to uncover our thoughts and motivations. Nevertheless, such deep reflection can leave us feeling uncomfortable, exposed, perhaps even vulnerable. Despite this, when reflection is meaningful, guided and carried out with compassion, patience and respect, it can rekindle our passion for dentistry and lead us to re-discover our motivation to be a dentist in the first place. We can even start to enjoy dentistry again.

Without the help from a mentor who acts as a trusted friend and advisor, PDPs run the risk of turning into another tick-box exercise with the bare minimum of thought going into it. This would be a tragic, wasted opportunity for the whole profession in our effort to deliver safe patient care.

Mentors act as sounding boards for us to bounce ideas with. They offer different perspectives especially if we happen to stray to a potential dead end. They help us understand that a dentist is more than clinical skills. Leadership and communication skills are vital in building trust and rapport with patients, without which we will not be carrying out any treatment. And in order to build trust and rapport with patients, we need honesty and integrity; honesty with our patients, with ourselves and our ultimate intentions. Mentors can help make us more rounded and balanced people so that we can ultimately deliver safer patient care. In essence, mentors help us to build greater, more lasting success.

Table 1 Distribution of learning style preferences in surgeons and physicians

Style	Activist	Pragmatist	Reflective	Theorist
Surgeons	48%	30%	22%	33%
Physicians	25%	15%	25%	50%

Mentors and change

Reflective thinking practice is a different mind-set which many of us are unaccustomed to. The publication of documents and regulation is one way of implementing change, yet we tend to instinctively resist change. Typically, we go along with it because we must comply and this could easily morph into a tick-box exercise.

Atul Gawande, an American surgeon and author, noted that change requires effort and the decision to change is a social process.[10] We are all aware that some new ideas can take off whilst others stall and fizzle out. The recent successful roll out of COVID-19 vaccines in UK hides the fact that there has been lower uptake of vaccines in some areas, particularly with ethnic groups.[11] Dr Farooqi, a family doctor, personally phoned his high-risk patients who had turned down the vaccination and after discussing their fears and concerns, persuaded them to change their minds. 91% of these patients went on to have their vaccines.[12]

Mentoring involves the human touch. It is not particularly hi-tech or sophisticated, but it reaches out to individuals in a personal way at a time when we need this human connection; this is something I explore more in the next article. Mentoring can nudge us in the right direction towards a more, deeper reflective practice.

Conclusion

Mentors act as trusted friends, advisors and help us adopt change for the better. They help us understand ourselves more and are cost-effective investments, making us better people and practitioners, capable of delivering safer patient care. Safer patient care *is* our *raison d'etre* and should be more than a tick-box exercise. If we practice evidence-based dentistry clinically, surely, we cannot ignore the evidence[13] that the corporate world already knows and practices: mentoring works. ◆

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