An UNDISCOVERED opportunity?

Mark James* says that it is time to develop supported learning and mentoring activities in dentistry for DCPs.

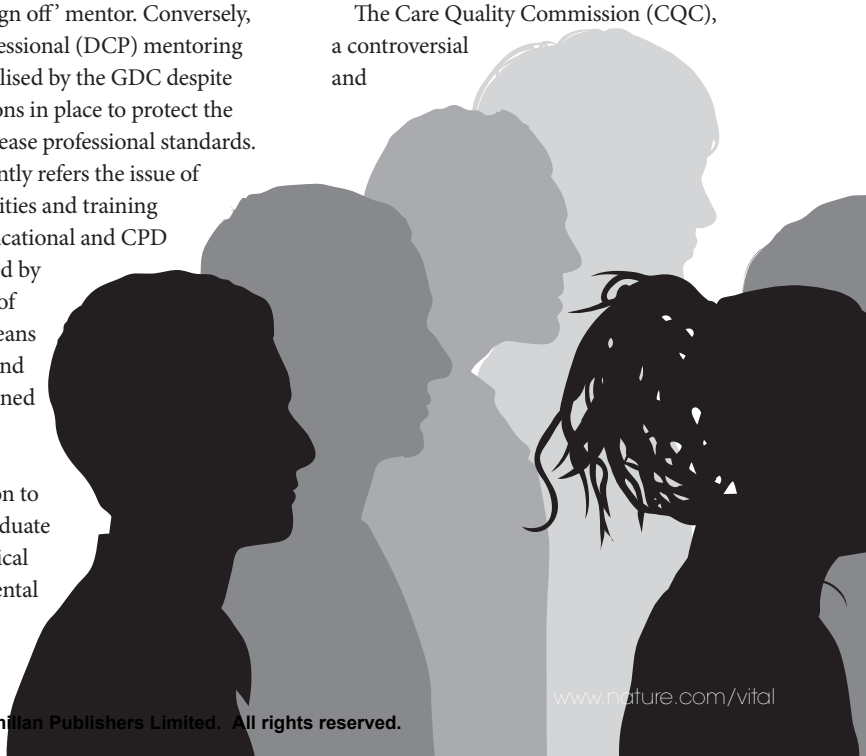
Mentoring is a concept that has been around for centuries. It spans time and cultures encompassing the spirit guides of Native Americans, historical and mythological associations to King Arthur and Merlin through to science fiction characters like Luke Skywalker and Obi Wan Kenobi. It is now becoming recognised and established within modern culture where initiatives for professionals and the public, in particular the socially disadvantaged, are encouraged to support and be supported to improve their working and personal lives through mentoring. Indeed, business and industry in both public and private sectors appears now to be embracing mentorship as part of personal and professional development.

Mentoring for DCPs

The mentor is described as 'a trusted and experienced advisor who has a direct interest in the development and education of a less experienced individual'.[1] In dentistry our regulatory and professional bodies promote lifelong learning through continuing professional development (CPD), but is mentoring embedded in these standards or scopes of practice to the extent of other health care professions?[2,3] Other health care professionals, for example members of the Nursing and Midwifery Council (NMC), have published standards to support learning in practice and include new standards for mentors and practice teachers with nursing and midwifery students.[4] Postgraduate professionals are guided within this structure, during training and for a single preceptorship year after qualification, and continue with competencies being validated annually by a supervising 'sign off' mentor. Conversely, dental care professional (DCP) mentoring has yet to be realised by the GDC despite greater regulations in place to protect the patient and increase professional standards. The GDC currently refers the issue of mentoring activities and training for DCPs to educational and CPD services provided by the Committee of Postgraduate Deans and Directors, and have commissioned the Centre for Medical and Dental Education to develop postgraduate dental and medical education for dental practitioners.[5]

The development of mentoring services from the Deaneries currently appears very limited, varying from a general lack of any training or guidance to a few, like the Northern Deanery, offering training and a mentoring service similar to that of the NMC. Other providers include the Faculty of General Dental Practice, the University of Lancashire and King's College London who offer level 3 studies varying in length and cost which might, to some DCPs, appear prohibitive and distant.

The Care Quality Commission (CQC), a controversial and



independent regulator of health and social welfare, offers guidance about compliance on essential standards of health and safety and recommends that staff are enabled to take part in learning and development that is relevant and appropriate so that they can carry out their role effectively.[6] Alarmingly, a 2009 revalidation feasibility study for dentists by Costley claimed that many practitioners in the dental sector are not currently meeting the minimum standards in terms of operational competency with a need for face-to-face assessment with all, or a selection, of dental professionals throughout the UK.[7] Revalidation builds on current standards to protect patients by asking dental professionals to demonstrate their suitability to remain on dental registers. The study made no mention regarding co-operation with or comparison to other health care professionals in addressing this serious issue.

My learning journey

These facts guided the direction of my learning journey which began with liaising with Philips UK to create a programme for mentoring, initially to provide professional support and guidance to newly graduated DCPs. A year's initial pilot was formulated based upon the framework document of preceptorship published by the Department of Health (DH) which is described as an individualised period of support under guidance of an experienced clinical practitioner.[8]

Learning styles

My training started at the University of Surrey where a selected team of DCPs began an established level 3 Mentorship Module with other allied healthcare professionals. We began by investigating Honey and Mumford's questionnaire which identifies individual learning styles.[9] They determined that we are either *activists*, who involve themselves in new experiences, *reflectors*, who stand back and consider experiences from different angles, *theorists*, who logically assimilate experiences and finally *pragmatists*, who practically apply new ideas and theories to see if they work. Individuals can display characteristics in some or all of the styles. In understanding their particular style the individual can then evolve their development more broadly by learning focused around their individual profile. I was surprised to discover that far from being a pure activist I was more reflective in my learning style.

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Knowing my learner

Applying learning styles, domains and theories into a practice scenario was the next assessed phase. I asked my student to compile both the Honey and Mumford and Fleming and Mills VARK (visual, aural, read/write and kinaesthetic) questionnaires.[9,10] I wanted to know how both would compare and if they would complement each other or give separate but compelling or confusing data. Knowing my learner was a pragmatic, reflective theorist with aural and kinaesthetic learning styles helped me deliver my teaching session effectively using the appropriate cognitive, affective and psychomotor learning domains. Additionally, after pre-presentation reflection, I considered the importance of learning theories in the assessment; in particular, Maslow's[11] humanistic approach which Quinn and Hughes[12] see as promoting the mentor as a helper or facilitator engaging independent learning and self-motivation. This contrasts with the behavioural and cognitive theories of stimulus-response and thinking-doing by emphasising significant aspects of human existence like feelings, attitudes and values.[12] Gopee[13] states that adult learners also bring with them experience and values that promote expectations and intent. This is supported by Megginson and Clutterbuck who believe that the most successful relationships are created by being mentee or learner driven.[14] Price concludes that mentors should put the learner and learning within the clinical setting to develop competence .[15] I did this to allow the student to feel in control of their learning experience within a non-threatening, relaxed and learner-centric work environment to allow their learning styles, opinions and preferences to lead the session. The session demonstrated a strong mixture of behavioural and humanistic approaches to develop knowledge, competency and confidence during the lesson. They enjoyed the introductory evidence-based PowerPoint presentation which focused on the standards that guide the process of clinical hand washing. I initially asked them what they knew of the process and this guided further questioning where I felt there were weaknesses; this reflects Gagne's Theory of Instruction which outlines the need to assess prior learning, and further evaluate performance by advocating demonstration and providing feedback on it.

Learning development

Dreyfus and Dreyfus describe learning development occurring in five stages.[16] The novice develops initial limited knowledge to being an advanced beginner, then applies acquired knowledge with greater flexibility to becoming a competent and then proficient performer who has accumulated enough experience to see what is most important in decision making. Finally, the expert evolves, no longer relies on rules and is subconsciously aware of their actions. Expert knowledge demonstrates an advanced ability to problem solve, organise, maintain and create knowledge. Benner adapted these theories to clinical teaching maintaining that the practical world is important for the development of nurses' skills and ability to care and placed a new value on clinical experience. This also helped educators and mentors understand what they could realistically expect of new graduates and how to help them develop into skilled nurses.[16]

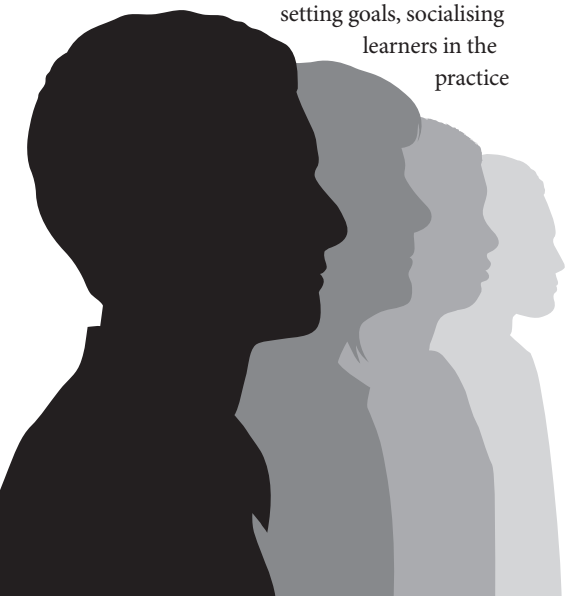
To complete the module a written submission concluded with the course being added to the learning development plan which incorporated all the other practical and academic elements of the course.

A mentorship culture

Costley's revalidation feasibility study identified several groups of failing but qualified dentists; included are those who studied and trained abroad and 'younger' dentists or those in postgraduate vocational training.[7] In dental hygiene training Ferguson[19] determined that 80% of US dental hygiene programmes were failing to offer student mentoring and Blanchard[18] discovered through surveys sent to hygiene programme directors that less than 30% used 'some type' of mentoring.

Could embedding a stronger mentorship culture into the important initial transitional period, and beyond, address performance and best practice within the clinical environment for the benefit of patient and professional alike?

Price believes the mentor is pivotal in setting goals, socialising learners in the practice



'Could embedding a strong mentorship culture address performance and best practice for the benefit of patient and professional alike?'

culture and understanding their anxieties and needs.[15] However, he goes much further by challenging the mentor to demonstrate and maintain an active interest in learning whilst continuing to create learning opportunities for their mentees.

Transitional support

The support programme is designed to promote excellence, innovation and development through adult learning with the participants being intrinsically involved in its structure, implementation and success. This process has already begun with mentors presenting to and asking pre-graduation students to create learning opportunities and guide the content of the programme. Other health care environments have and continue to provide opportunities to promote best practice and develop competencies through clinical based mentoring within their professional culture. We believe it is now time to develop similar supported learning and mentoring activities in dentistry for DCPs and Philips UK plans to develop further its commitment to them.[20]

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**Mark is a Registered Dental Hygienist working in Surrey and a Key Opinion Leader for Philips Sonicare.*