Positioning mentorship within Australian nursing contexts: A literature review

ABSTRACT

There are a variety of structured and unstructured supportive relationships available to nurses. Internationally, nurses commonly use preceptorship, clinical supervision, and mentorship to meet distinct needs and provide differing levels of commitment, intensity, and enabling functions. Of particular interest to the nursing profession is the use of mentoring relationships to support nurses in achieving leadership positions. In Australia, preceptorship and clinical supervision are freely used and understood by nurses however, mentoring relationships are less readily applied, and agreed meanings and understanding are lacking. This paper will explore the range of supportive relationships available to nurses. The terms used to define and describe these relationships, and how these relationships are contextualised, will be explored in order to better understand the position of mentorship for nurses in Australia. The potential value of mentorship in developing nursing leadership in Australia will also be identified.

Received 19 December 2005    Accepted 10 May 2006

Andrea McCloughen
PhD Candidate
School of Nursing
College of Health and Science
University of Western Sydney – Parramatta Campus
Penrith South NSW, Australia

Louise O’Brien
Associate Professor
Sydney West Area Health Service
Cumberland Hospital
Mental Health Nursing Research Unit
Parramatta NSW, Australia

Debra Jackson
Professor
School of Nursing
College of Health and Science
University of Western Sydney – Parramatta Campus
Penrith South NSW, Australia
INTRODUCTION

Over recent years the use of formal and informal supportive relationships in nursing has been advocated for a number of purposes including recruitment and retention, new graduate programs, development of clinical and management skill and expertise, and development of career pathways. Generally highly structured support is delivered using the frameworks of preceptorship, clinical supervision, and formal mentoring relationships, whilst informal mentorship occurs as a less structured, professional relationship (Morton-Cooper & Palmer 2000). Despite their broad application, the individual attributes of each of these relationships are poorly defined with terms frequently used interchangeably.

The nursing literature addresses in some depth the nature and frameworks of formal nursing relationships and widely acknowledges their merits (Wright 2002; Winstanley & White 2002; Morton-Cooper & Palmer 2000; Beattie 1998; Kitchin 1993). The benefits of preceptorship include support during role transition and orientation (Clare & van Loon 2003; Wright 2002; Morton-Cooper & Palmer 2000) whilst clinical supervision is highly valued for its contribution to developing expert clinical practice (Winstanley & White 2002). The benefits attributed to mentoring relationships include personal and professional learning, and growth; inspiration for life changes; skill development; attainment of professional goals and career progression; confidence, creativity and fulfillment of potential (Association for Australian Rural Nurses 2005; Borbasi, Jones & Gaston 2004; McKinley 2004; Beckmann Murray 2002; Klein & Dickerson-Hazard 2000; Morton-Cooper & Palmer 2000; Vance & Olsen 1998). In particular, mentoring relationships are viewed as integral to the future progression of the nursing profession (Borbasi et al. 2004; Cherry 2002; Moran et al. 2002; Norris 2002) because ‘Mentors play a critical role in the development of leaders’ and ‘having mentors is essential for aspiring nurse leaders’ (Rust 2005: 125); ‘Mentors can help provide the guidance and tutelage necessary to move the novice nurse leader into a strong position of leadership’ (Evans & Reiser 2004: 358).

Mentoring relationships for nurses have been widely discussed in literature from the United States (USA) and the United Kingdom (UK), however mentorship appears to have received less attention in the Australian nursing literature. Furthermore, the nursing mentoring literature points to differences in nomenclature and the way in which this relationship is understood and implemented (Theobald & Mitchell 2002; Watson 1999; Cahill 1996). These differences may result from the fact that mentoring relationships occur both as prescribed and formal or informal and spontaneous processes (Hurst & Koplin-Baucum 2003; Bennetts 2002; Vance & Olsen 1998) and also that there are differences in the way these countries understand and apply the relationship. Unfortunately the richness of nursing mentorship as a supportive relationship in human and career development, with specific relevance for nursing leadership, is potentially lost when it is subsumed into prescriptive activities.

In Australia, mentorship for nursing has only achieved recognition in the literature in the last 10–15 years (Madison 1994; Pelletier & Duffield 1994). This lack of an established history suggests that the Australian nursing profession’s understandings of nursing mentorship are most likely influenced by the USA and UK. This has resulted in a lack of clarity and common understanding and determines that Australia has yet to establish a nursing mentoring culture. At the same time, the shortage of information addressing formal and informal nursing mentoring relationships reveals a deficit of understanding about the extent to which these relationships exist, and the meanings Australian nurses apply to them. Furthermore, insufficient knowledge of mentorship by those nurses interested in leadership determines they may not avail themselves of its widely acknowledged benefits.
This paper will explore the range of supportive professional relationships for nurses within a contemporary Australian context. The Australian and international nursing literature on preceptorship and clinical supervision is briefly reviewed and then a more thorough review of mentorship is provided. The terms and processes used to describe these relationships will be identified and defined in order to better understand the position of nursing mentorship in Australia and its potential value in contributing to the development of nurse leaders.

**Preceptorship**

The preceptor is an experienced practitioner who provides transitional role support within a collegial relationship across a variety of clinical environments (Pickens & Fargotstein 2006; Morton-Cooper and Palmer 2000; Usher et al. 1999). The term preceptor is widely used in the nursing profession to mean a tutor or instructor, a ‘how to’ or ‘where to find’ person (Davidson & Elliott 2001; Kitchin 1993). Generally, preceptors are assigned or formally matched with learners and function within a structured framework based on the clearly specified learning needs of the individuals requiring support (Clare et al. 2002; Morton-Cooper & Palmer 2000). Preceptors support the learner nurse’s growth and development for a limited period of short duration (from a few weeks to several months) determined by the concurrent orientation programme, clinical allocation, and required objectives and evaluations (Mills, Francis & Bonner 2005; Wright 2002; Bick 2000; Morton-Cooper & Palmer 2000; Kitchin 1993). Preceptors play a dual role. While performing their usual clinical duties they assume the additional responsibility of guiding the new nurse on a one-to-one basis or closely within the same setting (Clare & van Loon 2003; Wright 2002; Morton-Cooper & Palmer 2000; O’Shea 1994; Kitchin 1993).

It is widely agreed that preceptorship involves an organisational dimension, a structural role dimension and also has an interpersonal emphasis (Leigh et al. 2005; Duke, Forbes & Strother 2001; Fowler 1996; Kitchin 1993; Hagerty 1986). However, debate exists regarding the degree of intimacy of preceptor relationships (Burke 1994). Morton-Cooper and Palmer (2000) identify that preceptorship is a functional enabling relationship rather than being intimate or personal, therefore, the preceptor provides collegial support and transitional socialisation. Consequently, when the relationship ends, in many instances the new practitioner will look beyond this prescriptive relationship towards one that is broader and more enduring in nature (Davidson & Elliott 2001).

Preceptors act on behalf of employers to assist with the clinical instruction of undergraduate nursing students, and help new graduates and newly hired nurses orientate and adjust to their new role (Pickens & Fargotstein 2006; Northcott 2000; Usher et al. 1999; O’Shea 1994; Deane & Campbell 1985). Preceptorship has been used extensively across the USA since the 1960s as an undergraduate clinical teaching strategy and in Australia preceptorship models for final semester undergraduate nurses are increasingly being used since the introduction of nursing university programmes (Robinson, McInerney & Sherring 1999; Duffy, Siegloff & Kent 1998; Beattie 1998).

In the early 1990s following a government study into post-registration education and practice, the UK introduced preceptorship to support and develop newly qualified nurses (Fowler 1996) and developed preceptorship packages as an effective nursing recruitment strategy (Leigh et al. 2005; Bick 2000). Similarly, the Australian Government endorsed formal preceptorship programmes for new graduates as a primary mechanism to facilitate transition from university to nursing work (Parliament of Australia Senate 2002). Within Australia preceptorship is also acknowledged as a strategy for nursing recruitment and retention and is commonly incorporated into graduate nurse
programmes (Firtko et al. 2005; Clare & van Loon 2003; Fitzgerald & Amadio 2001; Kitchin 1993).

**Clinical Supervision**

Clinical supervision has been a common practice for practitioners in counselling, psychotherapy and psychoanalysis since the 1920s but has come to the attention of the nursing profession in more recent times (Lyth 2000; Farrington 1995). Clinical supervision has become an established practice in the UK nursing profession since the late 1980s (Mills et al. 2005; Fowler 1996) and over the past decade for many nurses in Australia, particularly those working in psychiatry (Mills et al. 2005; Winstanley & White 2002; Platt-Koch 1986).

Clinical supervision relationships draw attention to the issues of clinical practice, namely ‘the quality imperatives, organisational demands, personal self-management and ethical issues that may arise in everyday practice’ (Morton-Cooper & Palmer 2000: 197–198). They provide a structured forum for empathetic support with the goal of improving therapeutic skills, the transmission of knowledge and facilitation of reflective practice (Clouder & Sellars 2004; Winstanley and White 2002; Lyth 2000; Morton-Cooper & Palmer 2000). Supervisors and supervisees are matched both by choice or allocation, and unlike preceptorship, clinical supervision generally occurs away from the clinical environment in a private context to support in-depth reflection. The supervision process varies between the needs of settings to include group and peer supervision (Edwards et al. 2005; Catmur 1995; Minot & Adamski 1989).

Clinical supervision lacks the prescriptive-ness of preceptorship and has a greater degree of intimacy. The in-depth reflection inherent to the clinical supervision process determines that a close and trusting relationship be established (Gray & Greenwood 2001; Nicklin 1997). This is illustrated by the significant degree to which the supervisee openly shares feelings, emotions, concerns, vulnerabilities and clinical problems with the supervisor (Farkas-Cameron 1995).

The clinical supervision relationship potentially benefits both the supervisor and supervisee. The supervisor may experience expanding knowledge as a result of the teaching-learning process and altruistic feelings of assisting another and advancing their profession (Landmark et al. 2003). The supervisee may experience heightened self-awareness, advanced clinical competence, refinement of skills, and increased ability to transfer knowledge to new situations (Farkas-Cameron 1995). Although local policy and organisational processes vary, in general, the structure and procedure of clinical supervision aims to enable the qualified nurse (rather than new or student nurse) to develop and sustain a high quality of professional practice through facilitated support and development (Gray & Greenwood 2001; Morton-Cooper & Palmer 2000).

**Mentorship**

Traditionally mentorship has not been associated with nursing, although Florence Nightingale reportedly acted as a mentor to matrons for some years, providing them with pastoral and personal care and management guidance (Lorenzton & Brown 2003). In contemporary nursing contexts, mentoring occurs in a variety of formal and informal ways and encompasses enabling and cultivating features that assist in empowering individuals within their working environments (Morton-Cooper & Palmer 2000; Northcott 2000; Andrews & Wallis 1999).

**Definitions of mentoring**

Consensus has not been reached about the definition of nursing mentoring relationships (Clutterbuck 2002; Theobald & Mitchell 2002; Watson 1999; Cahill 1996; Cameron-Jones & O’Hara 1996; Fowler 1996). Understanding remains elusive in part because of the interchangeable use of terms denoting supportive relationships including mentoring, preceptorship, facilitation, supervision, role modelling,
and sponsorship (Block et al. 2005; Firtko, Stewart & Knox 2005; Turnbull & Roberts 2005; Carroll 2004; Evans & Reiser 2004; Ehrich, Tennent & Hansford 2002; Chenoweth & Lo 2001; Morton-Cooper & Palmer 2000; Parsloe & Wray 2000). Although these relationships share common features, the mentoring relationship has depth and mutuality beyond the scope of the others (Madison 1994).

Mentoring is described as ‘a developmental, empowering, and nurturing relationship extending over time in which mutual sharing, learning, and growth occur in an atmosphere of respect, collegiality, and affirmation’ (Vance & Olsen 1998: 4–5). Morton-Cooper and Palmer (2000) propose that mentoring concerns the building of a dynamic relationship that embraces shared, encouraging and supportive elements based on mutual attraction and common values. Klein and Dickenson-Hazard (2000: 20) describe mentorship as a complex human phenomenon, ‘born out of a desire to learn and grow, [that] is fostered by mutual trust and respect, and is fuelled by common values and goals’. As these descriptions illustrate, mentoring is distinct from the prescriptiveness of preceptoring and is not directed by particular models or structures as found in clinical supervision.

Characteristics and functions of individuals within mentoring relationships
The mentoring relationship requires a high degree of involvement and commitment and demands acceptance, amicability, respect, trust and confidence in self and others. It necessitates both mentors and mentees to grow and expose themselves to all that life calls forth within them (Klein & Dickenson-Hazard 2000). Given this challenging process, it is clear that both members of the relationship require certain attributes to fulfil their roles.

The significance of the mentor’s personal characteristics is a common theme in the mentorship literature. Although the mentoring process lacks consistent definition, the essential characteristics of an effective mentor have been agreed (McKinley 2004; Beckmann Murray 2002; Chenoweth & Lo 2000; Morton-Cooper & Palmer 2000). Darling’s (1984) pioneering research in the USA, elicited characteristics of ‘valuable’ nurse mentors, proposing they be an envisioner, able to communicate a meaningful vision of the nursing world; an energizer, someone who exerts personal dynamism; an investor, willing to apply themselves to the mentee; and a supporter to provide emotional encouragement. These characteristics are reinforced by the mentor’s action orientations of being a standard prod- ducer; a teacher-coach; and being a feedback-giver. The mentor must also be an eye-opener; a door- opener; an idea-bouncer; and act as a problem solver. Finally a mentor must be a career counsellor and challenger stimulating critical thinking and deep exploration of issues (1984: 42–43). Vance and Olsen (1998) identify similar mentor characteristics and succinctly describe fundamental mentor attributes of generosity of spirit, self-confidence and liking oneself, competency, and openness to mutuality. Morton-Cooper and Palmer (2000) also encapsulate Darling’s (1984) work when describing mentor roles of adviser, coach, counsellor, guide, role model, sponsor, teacher and resource facilitator.

The literature refers to the person being mentored as a novice, learner, candidate, protégé, or mentee. The term protégé (Bower 2003; Beckmann Murray 2002; Klein & Dickenson-Hazard 2000; Vance & Olsen 1998; Short 1997; Playko 1995; Murray & Owen 1991) has been used regularly since Levinson and colleagues (1978) early descriptions of mentoring relationships and the term mentee has been in wide use since the 1980s (McKinley 2004; Clutterbuck 2002; Ehrich, Tennent & Hansford 2002; Morton-Cooper & Palmer 2000; Lacey 1999; Jacobson 1998; Darling 1984). The nurse mentee requires certain characteristics for the relationship to evolve and flourish. They should possess openness to receiving help, learning and
sharing; commitment to their career; competence; and strong self-identity and initiative (Vance & Olsen 1998). The mentee needs to be motivated and committed to learning; be responsible; be ready and available for feedback; believe in and accept the guidance provided; admire the mentor’s achievements; have ambition and confidence in their own careers; understand their own personal strengths and limitations; and possess their own visions (Bower 2003; Smith, McAllister & Snape Crawford 2001; Morton-Cooper & Palmer 2000; Lacey 1999; Hanneman 1998).

History of mentorship

The concept of mentorship is derived from Greek mythology in Homer’s classic tale *Odyssey*. When Odysseus, king of Ithaca, left home to fight in the Trojan War, he entrusted the care and nurturing of his son Telemachus to Mentor, a loyal and trusted friend. Mentor provided Telemachus with wise and sensitive counsel while grooming him to become the future king and developing him for the responsibilities he would assume in his lifetime. Mentor’s responsibilities required him to act as a guide, counsellor, tutor, defender and, at times, protector of Telemachus. Over time the word ‘mentor’ has become synonymous with trusted advisor, friend, teacher and wise person (Shea, 2002).

Few references to mentorship appear in the modern literature until the late twentieth century (Morton-Cooper & Palmer 2000). During the 1970s interest in mentorship was ignited as a result of a landmark study of adult male development from early adulthood until the late forties (Levinson et al. 1978). At this time, mentoring relationships were identified as complex and developmentally important, assisting young men to develop and grow, and move from one life stage to the next (Levinson et al. 1978). Levinson and colleagues (1978) promoted the concept that mentoring was advantageous to a protégé’s career and personal life and that the mentor also benefited in terms of having his career rejuvenated through the process of assisting another to learn and develop. This traditional or classical mentoring partnership is an informally established process wherein mentors and protégés come together spontaneously via mutual admiration and attraction (Morton-Cooper & Palmer 2000; Madison 1994; Levinson et al. 1978).

Throughout the 1970s, mentoring was promulgated as a predominantly male phenomenon, an extension of the ‘old boy network’ found in business contexts (Beckmann Murray 2002; Vance & Olsen 1998; Pelletier & Duffield 1994). In relation to career oriented women, mentorship was not apparent until the late 1970s (Vance & Olsen 1998; Vance 1982). Feminist recognition of the ‘old boy network’ may have been the triggering factor for the introduction of mentoring into the USA nursing context (Morle 1990). Mentoring began to move from a largely informal and discretionary activity toward being a more formal pursuit during the late 1970’s. The areas of education and health care recognised the potential learning and developmental opportunities that mentoring could provide and introduced formal mentoring programmes that enabled individuals who may not have been exposed to previous informal mentoring, particularly women, to be targeted (Ehrich, Tennent & Hansford 2002; Vance & Olsen 1998).

In Australia, mentoring is of fairly recent interest for nurses. As little as twelve years ago, mentoring for nursing was only beginning to receive attention and was acknowledged as being unfamiliar to many Australian nurses. With the exception of a few small studies of nursing academics, the incidence of mentoring in clinical settings was not widely reported (Madison 1994; Pelletier & Duffield 1994). Pelletier and Duffield (1994) analysed four research studies to ascertain the level of mentoring experienced by nurses across New South Wales (NSW). The primary purpose of the studies was unrelated to mentoring and no definition was provided, however the authors pro-
posed that while some NSW nurses were not lacking in mentoring encounters, fewer experienced them than their peers in the USA (Pelletier & Duffield 1999).

The USA and UK literature demonstrates that contemporary mentorship processes continue to occur both formally and informally amongst nurses at various stages of the experience spectrum and across a range of contexts (Byrne & O’Keefe 2002; Canham & Bennett 2002; Andrews & Wallis 1999; Watson 1999; Vance & Olsen 1998; Cahill 1996; Kavoosi, Elman & Mauch 1995). Similarly Australian publications reflect a variety of applications for the use of mentoring in diverse nursing settings (Association for Australian Rural Nurses 2005; Heartfield & Gibson 2005; McCloughen & O’Brien 2005; Mills et al. 2005; Waters et al. 2003; Chenoweth & Lo 2001; Lo & Brown 2000; Roberts 1997). The international literature cites multiple examples of formal mentoring programmes for nurses (See for examples; Block et al. 2005; Garwood 2003; Waters et al. 2003; Canham & Bennett 2002; Theobald & Mitchell 2002; Lo & Brown 2000; Suen & Chow 2001) although significantly less exploring informal/classical nursing mentoring relationships. Much of the literature on mentoring in nursing is embedded in opinion pieces or discussion papers (Watson 1999; Cahill 1996; Atkins & Williams 1995).

**Formal nursing mentoring programmes**

Formal mentoring programmes can differ in terms of purpose, context, duration and outcomes (Ehrich, Tennent & Hansford 2002; Shea 2002; Parsloe & Wray 2000; Murray & Owen, 1991). They provide structure to support the deliberate pairing of a more skilled and experienced person with someone of less skill and experience and aim to develop the mentee’s unique abilities (Lander 2004; Lacey 1999). Formal mentoring programmes are generally determined by organisational culture and often those involved will be obliged to achieve specific aims, purposes and outcomes as identified by the acknowledged programme of support and development. Depending on the degree of formality inherent to the programme, aims, purposes and outcomes may not be negotiable, individuals are most probably assigned or formally matched and duration of the relationship will be no more than 1–2 years (Morton-Cooper & Palmer 2000). In many ways these relationships resonate more closely with preceptoring.

Since the 1980’s, mentorship for pre-registration UK nursing students has been identified as important to maximising benefit from student clinical placements (Lloyd Jones, Walters & Akehurst 2001). However the pattern of mentoring within pre-registration education in the UK differs from traditional models (Atkins & Williams 1995) and has been referred to as pseudo-mentoring, because the relationships are short-term, focus on specific outcomes, and occur with little or no choice (Aspinall & Siddiqui 1996). In Australia this would be considered to be more in line with some form of extended preceptorship.

Recent literature addresses mentorship schemes for undergraduate Australian nurses (van Eps et al. 2006; Nursing Review 2003; Robinson 2003; National Rural Health Alliance 2002) although formal research focusing on mentoring in this context is lacking. Similarities and differences between Australian and English programmes are identified. A formal mentoring programme for second year undergraduate nursing students in NSW found elements of preceptoring with emphasis on the value of practical experiences and integration into the hospital environment (Lo & Brown 2000). Likewise, a formal mentoring scheme for final year Queensland undergraduate nursing students, focused on the acquisition of clinical skills (Theobald & Mitchell 2002). This emphasis on clinical experience is aligned with notions of promoting positive transition into work environments, and fits with a preceptorship
framework rather than mentorship. Also in Queensland, Van Eps et al. (2006) formal mentorship program organised to meet final-year student nurses' practice-based learning needs points to a strong alliance with preceptorship, as student learning outcomes included practical skills, basic care, time management, and culture and routine of the unit.

In the UK, mentorship within adult nursing contexts, has primarily concentrated on student nurses (Marrow & Yaseen 1998). In contrast, in the USA formal mentorship programmes for new nurses are widely used as 'a strategic approach to retention and recruitment' (Greene & Puetzer 2002: 63) with the aim of contributing to new staff satisfaction, creation of positive working environments and retention of current staff (Block et al. 2005; Carroll 2004; McKinley 2004; Hurst & Koplin-Baucum 2003; Fawcett 2002; Greene & Puetzer 2002; Prevosto 2001).

As little as over a decade ago, Pelletier and Duffield (1994) found that the incidence of mentoring in non-academic Australian nursing settings was unreported. Currently there continues to be a lack of research literature reporting on mentoring of Australian nurses in clinical contexts. It may be surmised that increased references to mentoring for nurses will occur in the Australian literature over the coming years as formal mentoring programmes are implemented nationally. In part, this change in organisational practice will occur in response to the ‘Report on the Inquiry into Nursing’ (Parliament of Australia Senate (PAS) 2002) that recommends development of formal mentoring programmes for new graduate nurses. Interestingly this comprehensive report does not differentiate between preceptorship and mentorship processes. Failure to delineate between terms illustrates the taken-for-granted nature of these expressions, whereby they are seen as having a certain meaning, thus not requiring definition.

Mentoring relationships are widely used in the USA to promote career development and socialisation of nursing faculty. Faculty members report experiencing career and psychosocial benefits and identify mentoring along traditional lines (Brown 1999; Short 1997; Kavoosi, Elman & Mauch 1995). In Roberts’ (1997) Australian survey of the scholarly activity of 714 nurse academics, over half of the participants agreed that mentorship from senior colleagues facilitated scholarly productivity. This was consistent with findings from the USA (Kavoosi et al. 1995; Megal, Langston & Creswell 1988). Many of Roberts’ (1997) participants also identified a lack of mentoring from senior nurse colleagues. Roberts (1997) suggests that those individuals who led nursing into the Australian university system may not have had mentors and perhaps do not know how to mentor others or even credit mentoring as an aspect of their role. The study highlights that the Australian nursing profession has yet to develop the mentorship traditions established in other disciplines and identifies a need for formalised nursing mentorship programmes to facilitate scholarly productivity (Roberts 1997). In a more recent study of the scholarly productivity of 156 Australian nurse academics, 67% identified mentoring as highly facilitating and a positive relationship between strength of important mentoring relationships and perceptions of whether or not they had published sufficiently by university standards was recognised. However, the study also highlighted that more than a quarter of the sample had never experienced mentoring, and those best equipped academically to provide mentorship, ranked it as less important to them personally (Turnbull & Roberts 2005). Although these findings resonate with Roberts (1997) study, the impact of burden of workload and non-supportive cultural climates on academic mentoring were also highlighted (Turnbull & Roberts 2005).

Waters et al. (2003) report on a NSW formal pilot mentoring programme for new nurse managers. In this study mentoring is defined as an alliance between two people, which creates a space for dialogue, resulting in their reflection,
action and learning (Rolfe-Flett 2000). The programme aim and the definition of mentoring informing the programme, strongly parallel components of a clinical supervision arrangement rather than traditional aspects of mentoring. Programme participants identify prior experiences of mentoring relationships from their professional lives, suggesting that mentoring is recognised and practiced among nurses in NSW. However descriptors of these relationships are not provided. It may be the case that if respondents are basing their prior relationships on the mentoring definition provided for the formal programme, they may in fact have been reporting on clinical supervision relationships.

Mentorship has gained prominence in nursing research to enhance quality and quantity (Byrne & Keefe 2002). In the USA mentorship in this context, has been viewed as ‘less than true mentoring because it is not established as a voluntary relationship based on commitment to an individual’, despite the supervisor–doctoral candidate relationship being close, long-term and including mentoring activities (Byrne & Keefe 2002: 393). Morton-Cooper and Palmer (2000) discuss the concept of ‘pseudo-mentoring relationships’ occurring when mentoring approaches are superficial. The authors identify academic involvement in thesis preparation as an example. Formal relationships occurring during orientation and induction programmes are also viewed as not ‘true’ mentoring, by these authors. In the Australian nursing setting, the supervisor–doctoral candidate association is more attuned to traditional mentoring relationships because it occurs by way of choice, has core components of trust and respect, nurturing and mutual sharing and adapts to the changing needs of the candidate-mentee. Often these relationships continue beyond completion of the degree.

Informal or ‘classical’ nursing mentoring relationships
Classical mentoring relationships are intimate learning alliances occurring when two individuals are naturally drawn to each other, as a result of chemistry, mutual attraction, shared interests and commitments. This individual selection is vital because the right interpersonal dynamics must exist for classical mentoring to develop (Morton-Cooper & Palmer 2000; Madison 1994). This contrasts with formal mentoring when there is no guarantee that a unique nurturing bond will develop between assigned individuals (Fawcett 2002).

The meaning and construction of classical mentoring relationships results from internal dynamics that depend upon interpersonal communication, empathy and rapport and individuals’ willingness to spend time, learn from, and share with, each other (Lander 2004; Bennetts 2002; Morton-Cooper & Palmer 2000; Hays, Gerber & Minichiello 1999; Vance & Olsen 1998). Classical mentoring is ‘part intuition, part feelings and part hunch – made up as you go along, and composed of whatever ingredients you have available at the moment’ (Shea 2002: 12). The classical mentoring relationship is emphasised as complex and elusive by Vance and Olsen (1998: 5) who propose it is ‘Difficult to define and measure. It cannot be seen, but … can be described by those who experience it’. Classical mentoring relationships are usually named retrospectively when individuals are appreciated and honoured by learners for what they have done, rather than naming mentors in advance in anticipation of what they might do, as seen in formal relationships (Bennetts 2002). This is easily understood given the spontaneous and unplanned creation of many mentoring relationships (Bruker & Charlie 1998; Cooke 1998; Erni & Greenblatt 1998; Watson Lubic 1998).

The nature and terms of classical mentoring relationships are set informally by those involved, unlike formal mentoring programmes where organisational imperatives can influence the relationship. The resulting partnership provides unstructured learning support rather than highly structured prearranged and specific
frameworks for development (Bennetts 2002; Morton-Cooper & Palmer 2000). Classical mentoring relationships are inherently of the individuals’ own making. The nature and evolving processes of the relationship and any expectations that may arise, will relate to what the mentor and mentee deem important. So as individuals advance through their careers, classical mentoring relationships can adapt and transform in tune with their needs.

Intense, emotional, intimate, loving, unconditional-positive-regard, enduring, and friendship are terms often associated with classical mentoring (Ehrich, Tennent & Hansford 2002; Morton-Cooper & Palmer 2000; Vance & Olsen 1998; Madison 1994; Levinson et al. 1978). Bennetts’ (2002) study identifies the taken-for-granted normality of the emotion and intimacy felt by mentees for mentors. Participants identify love, deep personal closeness, heightened communication, intuition, and creative energy within the classical mentoring relationship. It is natural for friendships to develop during these relationships because of mutual attraction, shared interest and deep personal connections. They may even evolve into lasting, lifelong friendships extending over long periods of time.

In particular, among women and nurses, they often endure through many cycles of change and growth, with some flourishing for 30–40 years (Fawcett 2002; Morton-Cooper & Palmer 2000; Andrews & Wallis 1999; Johnson, Geroy & Griego 1999; Jacobson 1998; Vance & Olsen 1998; Madison 1994).

Sharples’ (1998) South Australian study illustrates that classical mentoring has a favourable impact on local nurse leaders. Of seventy-seven randomly selected directors of nursing, more than half experienced having a mentor at some point of their professional lives and this mentoring was most prevalent at the early stages of their professional development. Participants report that their voluntary and mutually initiated relationships contributed to job satisfaction, knowledge, skills, and career progress. A strong mentoring generational legacy among those directors of nursing that had been mentored was found, with many of them more likely to support others’ careers (Sharples 1998).

**Mentorship and nursing leadership**

The mentor–leadership connection is a strong one because their characteristics and functions are consistent. The mentor is viewed as a career role model, adviser, guide, inspirer, information-deliverer and promoter and these are mirrored by leader characteristics which include being a positive role model, taking responsibility for growth and development of others, enabling others to act, and inspiring a shared vision (Evans & Reiser 2004; McKinley 2004; Milton 2004; Beckmann Murray 2002; Byram 2000; Klein & Dickenson-Hazard 2000; Kouzes & Posner 1995; Fields 1991). The literature points to the mentor being a nurse leader (Milton 2004; Bower 2003; Piemonte 1998; Vance & Olsen 1998). O’Malley (1998) claims that mentoring is an essential tool of the new breed of nurse leader, and Hockenbery-Eaton and Kline (1995) believe that an effective nursing mentoring relationship must include among other things, a mentor who is also a leader. In Corning’s (2002) study of 20 senior nurse executives from across the United States of America, mentoring was identified as an important skill of leaders.

The relationship between mentoring and nursing leadership is not a recent one, although more formal articulation of these combined processes may be (Fields 1991). Mentorship is reported as central to developing future nurse leaders (Daniels 2004; Milton 2004; Washington & Ditomassi 2004; Cherry 2002; Moran et al. 2002; Kelly & Aiken 1998; Vance & Olsen 1998). Nurse mentors have a responsibility to help mentees develop nursing leadership skills and encourage them in ‘taking the lead’ (Bower 2003: 391). Mentors can provide novice nurse leaders with the guidance and tutelage necessary to move into strong leadership positions.
In Australia, this connection has also been acknowledged by Moran et al. (2002) whose study found that nurse manager leaders identified individuals who displayed mentoring characteristics as being influential to their professional development.

**DISCUSSION**

In Australia, preceptorship and clinical supervision programmes for nurses are clearly understood and accepted and are implemented across the wide range of nursing contexts in similar ways to the UK and USA. Primarily preceptorship relationships are functionally enabling within a formal prescriptive framework. They incorporate clinical taskwork and transitional issues and address the wider concerns of recruitment and retention. Clinical supervision relationships, although not prescriptive are highly structured. They are focused on encouraging indepth reflection with the aim of progressing clinical practice and developing expert therapeutic skills.

Australian nursing lacks an overt recognised tradition with the concept formally known as mentorship. Recent recognition of the mentoring process for nursing in this country, has determined a need to take direction from our overseas counterparts who have historically established connections with mentorship. Mentoring is conceptualised quite differently in the USA and the UK, although both countries have made significant contributions to nursing mentoring literature. The USA acknowledges an intense emotional dimension to the mentoring relationship, whilst the UK essentially positions it as a work-based learning relationship. The USA prefers to situate nursing mentoring within a traditional or classical framework, whilst the UK is predisposed to position mentorship within a structured, formalised framework. Australian literature reveals that both formal and informal mentoring processes exist however, the majority of the literature reports on formal mentoring programmes. When preceptorship and clinical supervision are positioned alongside mentorship, which lacks an agreed definition and is applied variously across countries, it is understandable that components of these relationships may have impacted on Australian interpretations of mentoring and emerged in local nursing mentoring programmes. In addition, the unsystematic and unrestricted nature of classical mentoring may have determined a preference for that which is familiar and easily applied. The Australian literature illustrates nursing mentoring relationships that reflect the prescriptiveness of preceptorship and the structure of clinical supervision.

Benefits of mentoring relationships for nurses of all professional levels are widely acknowledged in the literature. These include personal and professional learning, and growth; inspiration for life changes; skill development; attainment of professional goals and career progression; confidence, creativity and fulfilment of potential. In particular, the generative impact of mentoring relationships contributing to the development of nursing leaders is reported. Significantly, literature from the USA identifies the use of mentoring relationships for nurses aspiring to leadership positions. Mentoring is seen to assist nurses as emerging leaders, cultivating their flexibility, adaptability, judgment and creativity. Interestingly there is a lack of Australian literature exploring the nursing mentorship—nursing leadership connection.

**CONCLUSION**

A review of the literature reveals that a range of issues has influenced the development and application of nursing mentoring relationships in Australia. The relative infancy of the concept in this country, the direction mentoring has taken in other countries, a lack of clear definition of mentoring and familiarity with other supportive relationships in nursing, have all impacted on the formulation of nursing mentoring locally. It is also apparent from the literature that the con-
cept of nursing mentoring is not as firmly established in this country, as it is overseas.

Similar to preceptorship and clinical supervision relationships, mentoring connections are also acknowledged as highly beneficial for nurses across a range of contexts. The reported benefits of mentorship should become more apparent for the Australian nursing workforce as the development of formal mentorship programmes increase. The significant value of nursing mentoring relationships for preparation of leadership roles and leadership succession has lacked attention in Australia. However the potential of mentorship for developing quality leaders and thus strengthening and progressing the nursing profession should not be overlooked. There is a need for successful nurse leadership as a means of providing stability within the ever-changing and dynamic Australian health care environment and to ensure that the profession continues to move forward.

References
Association for Australian Rural Nurses (2005) Mentor development and support project: Evaluation Forum Report March 2005. An evaluation forum jointly sponsored by the Association of Australian Rural Nurses (AARN) and the Royal College of Nursing Australia (RCNA).
Clouder L and Sellars J (2004) Reflective practice and
Andrea McCloughen, Louise O’Brien and Debra Jackson


Positioning mentorship within Australian nursing contexts


O’Malley J (1998) The head nurse, mentorship,


