Mentoring in the clinical setting: Process, issues and challenges

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Abstract: Mentoring in academic medicine requires the trained mentor to commit time, purpose and dedication for the personal and professional development of three categories of protégés or mentees i.e. medical students, the clinician-trainee and the clinical-educator. Conventionally, assigned mentors monitor the progress of the first two categories of personnel as their career pathway is clearly defined. On the other hand the clinician–educator in academic medicine could be a scientist or a career clinician expected to contribute to medical education activities and research. The clinician-educator has grown in complexity as he multitasks in providing clinical care, assists in delivering the medical curriculum and is expected to do research and publish. Although there is dearth of research in mentoring the clinician-educator, it is clear that mentored clinical-educators are more productive by way of scientific publications. Trained mentors are expected to identify the needs of the mentee with regards to the level of his career development and his aptitude to move up the academic ladder, successfully nurturing the maturation process. Processes of mentoring in the clinical setting, attributes of the successful mentor and facilitating the mentee in overcoming challenges in academic medicine are discussed.

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Introduction

The job of a clinician has grown in complexity from the conventional carer of the sick to take on more sophisticated roles as a teacher, educator and trainer. In academic medicine, although he continues to perform the function of a healer and trainer, his scope of responsibilities has grown beyond the hospital and operating theatre. Medical education has grown rapidly giving credence to the logically derived spiral medical curriculum incorporating assessment and evaluation.

This has required the clinician working in the academic environment (academic medicine) to take on new roles referred to as clinician-educator, clinician-scientist and master teacher.[1,2]

The clinician-educator (CE) is relevant in the clinical setting and moves through levels of seniority eventually taking on professorial duties through his contributions to scholastic writing and research apart from teaching and using his clinical skills in the hospital. The Master Teacher (MT) also takes on even larger responsibilities to teach, coach, mentor and counsel both students and junior faculty.

What is Mentoring?

Mentoring, a process traditionally prevalent in organizations was to identify potential candidates among the employees who could be 'tutored' eventually to take on senior positions. In the clinical setting and academia such an approach is largely less relevant as the duties of the CE are different and all faculties are expected to take on the responsibilities of academic medicine, albeit at differing levels. Mentoring can take various forms, both formal and informal, to make mentees or protégés see the bigger picture, to understand how an organization works, and to help personal and professional development. Derived from Greek mythology (Odysseus and Mentor), the mentor is a teacher and guide who assists in the growth of the mentee and has been extensively used in academia for successful academic medical career.[3]

Mentoring a junior colleague is different from coaching, teaching and counselling though elements of each of these attributes will be inherently exhibited when mentoring. The 'coach' pushes the mentee to achieve his goals; he clarifies and shows the way forward, the 'teacher' contributes to improving insufficient knowledge of the mentee so as to become competent in his scope of work. 'Counselling', on the other hand involves pulling the mentee out of emotional conflicts through a period of professional engagement.

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Confidential approaches to adopt coping mechanism to overcome personal problems and conflict are apparent in counselling. Another way to express the concept of counselling, coaching and mentoring is that counselling focusses on the past (experiences and conflicts) while coaching looks at the present state and changes to be made for the future. Mentoring is a plan developed for the future exploring potentials and working towards achieving set goals.[4,5]

Mentoring requires working with the mentee or protégé to achieve the goals as the latter has inadequate experience. Because of the need for a 'hands-on' approach, the mentor will have the attributes of a parent nurturing a child over the period of engagement, the need for a value system is inherent and the mentor takes the mentee through thick and thin.

Mentoring in the Clinical Setting

In the clinical setting, the mentor who is most often an experienced faculty, is tasked to address three groups of people who would be his mentees or protégés i.e. junior faculty, postgraduate students working towards their fellowship and medical students. Junior faculty may take two different pathways which include the clinician scientist who spends a majority of his time in research and the clinical-educator who does a large proportion of time in clinical care and is also tasked to teach.

This article discusses the attributes of the mentor, the value of mentoring in the clinical setting, challenges faced by the clinician-educator and experiences the author has had in mentoring.

Aspects of Mentoring

Mentoring clinical students in an academic department has been shown to be effective in fostering personal and professional development if the relationship is well established. Role modelling, perceiving existing weakness in early growth, ensuring the mentee stays on the chosen path and moves forward with an understanding of the university's doctrine enshrined by the domains of medical education is integral to preparing him for a professional position on graduation.[5,6]

A similar dynamic relationship is established with trainee lecturers (postgraduates) and junior clinician-educator mentees. The aspects of the organizational structure will become clear if the mentor involves the mentee as a whole person as the junior clinician-educator is often a novice in his new position apart from having acquired a higher clinical degree. He will inevitably be tied up with the multifaceted aspects of academic medicine i.e. clinical practice, teaching and learning and research, all of which can be daunting.

An analogy of this dynamic relation is simplistically illustrated on how an inexperienced ox (mentee) is tied to the yoke borne by an experienced ox (mentor) to plough the field; the mentor works side by side, ever present to guide and nurture the junior faculty or mentee to success.

The Process of Mentoring

As mentoring requires both time and planning, a process needs to be put in place. This process has an overarching philosophy of leadership, mutual trust and commitment. Hence the mentor has to be accessible and available. It is imperative to establish the mentee's aptitude and attitude to assigned duties and career development from the time of initial engagement. In this respect elements of coaching and counselling will become apparent. Hence it becomes clear that the mentee must exhibit maturity and the mentor provides the support. Researchers have discussed the value of both dyadic and peer relationship, both deriving benefits and reward.[6,7]

The question of assigned mentoring is both controversial and debatable. It appears to be logistically applicable for medical students and trainee-lecturers. Assigning mentors for clinical students is common practice because of the large number of students which makes it near impossible for students to select their mentors. In order to select a mentor to establish

the trust and commitment required of the mentor, one needs to consider how experienced the mentor is and if he is capable of mentoring. More often than not the mentor for a clinician-educator is an advanced career incumbent. He may be mentoring more than one mentee and such a relationship appears to set in very well in the clinician-scientist model where clinical responsibilities are diminished and job specifications are less diverse than the clinician-educator.

Mentees may be permitted to select their mentors but this may not be workable when the organization is small, effective mentors are few or when the nature of the work varies as is often the case in the clinical setting. The organizational framework would dictate how mentors are assigned. Feldman *et. al*, in a study involving 464 faculty mentees noted that more than a third could not find a suitable mentor. Most of these needed assistance finding a mentor. Junior faculty without a mentor felt isolated with a feeling of not set having set in nicely within the department or institute.[8] Full professors take on more mentees than associate or assistant professors with a maximum number of 6.7 in one institute. Co-mentoring was more common for non-clinical investigators with the benefit of increased experience. However there are often barriers to co-mentoring which include unclear expectations, disagreement and competition. Clinicians appear to report more long-distance mentoring compared to non-clinician mentor.[9]

Cross-gender pairing has been a debatable subject as the mentor -mentee relationship needs to be maintained at a professional level and moral boundaries are closely adhered to.

Whatever method opted for needs to contain the elements integral to an effective mentoring process that incorporates leadership qualities, commitment and trust together with an assured feedback system to meet the objectives of mentoring. As the relationship is reciprocal and dynamic, the right chemistry must develop for the development of productive careers in academic medicine.[10]

The attributes of a good mentor are itemized by Micki Holliday[11] as follows:

- Know your work
- Know your organization
- Learn to teach
- Learn to learn
- Be patient
- Be tactful
- Take risks
- Celebrate success
- Encourage your mentor to be a mentee

The basic tenet of mentoring is to reflect on what the mentor went through his past as far as challenges are concerned so that he can rely on his experiences in facing questions posed by his mentee. The organization has its vision, mission and core values with clear procedures and policies. Hence the mentor can lead the mentee on how things are done and achieved in the process. As there is a need for commitment and tolerance, the mentor will need to assign time for the mentoring process. The value of the internet should be exploited if time constraints are a barrier as the mentee can pose issues through the electronic media for the mentor to respond at times appropriate for him. Keeping the channels open gives strength to the mentor-mentee process and contributes to the trust required of the relationship. The clinical-educator mentor is equally busy with his tasks of the day, hence time management is essential. As both teaching and learning are attributes the mentor should have, keeping abreast of pedagogic principles, technological advances in adult learning, current views of academic medicine and updating own knowledge in his area of expertise are vital for a successful mentor-mentee dyad. Risk taking and being tactful are opposites of mentoring but equally applicable depending on the circumstances.

Risk taking applies to situations where mentees need to be challenged in incremental amounts to test their potential and capability. When a student mentee has

completed a task he can be stretched beyond the assigned job as is enshrined in Vygovsky's learning theory of 'zone of proximal development'.[9]

A similar process can be adopted in the dyadic relation between the mentor and the clinician-educator mentee. Of course when the expectation is beyond that of the mentee, one needs to be careful in pulling back a little to match his capability so as to permit more learning lest frustration sets in.

The value of mentoring in the clinical setting

Mentoring the clinician-educator has been shown to increase skills in preparing for research compared to those without mentors. Equally improved is their satisfaction in all activities related to academic medicine viz. teaching-learning, fulfilling organization's goals and in obtaining funding for their research. These activities enhances the faculty as an effective member of the institution.[13,14]

Levinson et. al (1991) reported on a survey of 558 full time female faculties in the Department of Medicine (USA) who had dedicated mentors.[15] There was an overall satisfaction especially where there was a good role model. Larger number of scholastic publications came from those with mentors than those without. Clearly mentors play pivotal roles in assisting time management with continuous support in furthering their research aspirations.[15]

Junior clinician-educators appear to retain a low threshold for a continued career in academia for various reasons apart from financial reasons. Eleven per cent of men and 20% of women , in a survey of 317 surgeons left academia because of work stress, dissatisfaction with career advancement (which often is related to insufficient contribution to research and publications) and inadequate mentoring.[16]

On the other hand effective and committed mentors act as excellent guides to improved work performance in the clinical field and also remain the underlying force for increased scholastic writing.[2]

The Clinician-scientist and Clinician-educator

The difference between the clinician-scientist and the clinician-educator is distinct as far as scientific research is concerned. The multitasking activities of the clinician educator are a reason for clinicians shying away from research and publications required of academic medicine. The large proportion of their time is spent in clinical duties with re-organization of their schedules to complete assigned teaching-learning activities, mentoring clinical students, performing administrative duties and other assigned jobs like partaking in corporate and social responsibility activities. On the other hand the clinician-scientist has little clinical assignments which free him to focus on research and scholastic writing. Chew et. al (2004) illustrated this trend through a survey done in one medical school where clinician-scientists were compared to clinician-educators. An odds ratio of 5.8 was noted and this finding persisted when adjusted for age, fellowship training and years of experience as a faculty.[2]

Although research is dearth on the effects of mentorship on the careers of clinician-educators there is a general feeling that this group of faculty have a lower scholarly productive rate than research based scientists. This issue appears to be present even among those who have mentors indicating that other factors mentioned under multitasking appear to contribute.[17,18]

Identifying the needs of a mentee

Although asking the mentee to select his own mentor may be ideal, in small organizations this may be difficult and one may rely on assigned mentors. Before one begins the mentoring process both parties need to clarify the role of each and the level the mentee is in his current position, his aspirations as a clinical-educator and intentions in the clinical setting. For junior faculty he may be a trainee doing a postgraduate degree in clinical medicine or could be a qualified specialist employed as clinical-educator.

The tasks expected of a junior faculty clinician-educator may be influenced by the needs of the institute and teaching may be fundamental to the appointment. In this situation clinical teaching skills, curriculum development based on the learning model developed by the institute, curriculum assessment and educational research may be areas that the faculty needs to develop skills in. Opportunities for development of these skills should be created and the mentor can guide the process.

A mentee faculty who is to take on academic research would need to develop skills in research methodology and proposal writing. He would have to be able to write scholastically and would need to be GCP certified. He should be competent in performing his tasks ethically, develop skills in grantsmanship and improve his negotiating skills through the mentoring process to seek both internal and external funds for research. Again the clinician-mentor is expected to facilitate the necessary skills required of the mentee.

It is incumbent on the mentee to have developed the pathways for personal and professional development by being self-reflective with an inbuilt self-appraisal system. If the mentee clearly defines his career goals and needs, both in the short and long term, the mentor would be able to appraise the global picture of his mentee's career pathway and be prepared to nurture the process till maturity is attained. Targets are best set by the mentee negotiating with the mentor as how they can be achieved over a period of time as dictated by the circumstances of the appointment and the level of his career, whether it is early, midlevel or advanced.

Medical students as mentees are easier to manage as they have fairly well established development pathways. If assigned mentors of medical students can retain their relation for an extended duration till they graduate, complete attainment of goals and maturation can be seen to take place.[19]

Wilkerson and Irby[20] categorized the career development stage of clinical-educators which is relevant to medical universities. The novice recruit is the entry level educator who has completed his postgraduate training and would benefit from learning basic teaching skills which could be learned through formal or informal but structured teaching within a short period. He would be slowly 'broken in' so as to function in the academic institute comfortably. Pedagogy requires knowledge of educational psychology, learning theories and instructional education and should appeal to the next level of educators who have the basic concepts. The next stage of development to enter would be for the intermediate clinician-educator who would grasp the fundamentals of curricular design and curriculum development and be well versant in the various methods of assessment, evaluation, educational outcomes and educational research. The mentor would be able to gauge the progress of the entry level educator and his capability to progress.[20]

Facilitating mentoring based on aptitude

Although mentoring is not about coaching and supervising, in the clinical setting where several issues are prevalent, the mentor may have to utilize slightly different approaches so as to 'liberate the mentee' to meet his true potential. Clinician-educators would have qualified with their postgraduate degrees and are marketable as professionals in the private sector. On the other hand to move up the academic ladder they have to be involved in scholastic writing apart from performing their clinical tasks. As a role model, advisor, counselor and confidante, it is imperative for the mentor to recognize the signs and weaknesses so as assist the mentee complete the maturation process. Stress, poor time management, frustration with promotion prospects and lack of direction are common reasons for clinical educators to leave academic medicine. Multitasking, administrative duties and lack of support or poor mentorship are other contributing factors.

The mentor plays a pivotal role in detecting these 'fractures' in career development and needs to assist in mending the perceived weaknesses. The trained mentor could help work on the mentee to rectify some areas using

the Hersey and Blanchard's framework.[21] The Hersey and Blanchard 'four development level' framework helps the mentor identify differing levels of mentoring in supporting or directing behavior. Categorizing the mentee into levels of development would be appropriate within a short period of engagement with the mentee into:

D1.   Low competence; high commitment

D2.   Some competence; low commitment

D3.   High competence; variable commitment

D4.   High Competence; high commitment

Serving as a role model, a counselor and an advocate for an understudy the mentor will have frank discussion on perceived obstacles and determine if there are emotive issues involved that is hampering progress. In this instance a counselor role is taken. Reality checks places the mentor in a better position for mending 'the fence'. The aim is to support and enable the mentee through till he is able to sustain himself; what is referred to as enabling completion of the maturation process.

In the Hersey and Blanchard development level model, they advocate a more structured and controlled supervisory approach for those in D1 as the issue is low competence. The teacher's role becomes apparent with a high element of supportive behavior. In D2 the mentee exhibits some competence and low commitment. This is a worrying group who need close supervision beyond mentoring. More direct supervision and support is required. For D3 category, although the competence is high, commitment is variable and there is a need for consistency. Less directive behavior is needed in this group but a listening ear with words of praise and facilitation would be sufficient. The D4 group can be facilitated with decision making to be done on their own with little need for overseeing the day to day responsibilities.

Time, Trust and Maturity

Time for the mentee is essential and hence the mentor will have to create dedicated times for the mentee. This is the commitment to the relationship that was mentioned earlier. Although face to face interactions are appropriate the email has become an equally effective means of communication, whether in real time (with face time and Skype) or through mail. Time management is integral to the mentoring process so that spare time is created for the mentee by re-scheduling one's own duties and delegation of work to others so as to create time for the mentee. A good mentor would have derived a working formula so that he would perhaps use 10-15% of his time for mentoring activities.

Nurturing the protégé or mentee is likened to minding a child as much needs to be done in evaluation of confidence and competency in the beginning and assessing learning outcomes through facilitations and regular feedback. Holliday[11] mentions emotional maturity as part of the mentoring process in both parties. Handling emotional conflicts, especially when dealing with the non-enthusiastic and uninspired mentee, can be both daunting and depressing. Control of anger and patience are vital. It is said that mentoring needs to be looked at as a rewarding event, the fact that there is a junior faculty looking up at the mentor for inspiration and leadership! Pacing with the mentee and walking through issues are rewarding and potentially fruitful in completing the maturation process.

Challenges faced by the Mentee

New faculty who have had no experience in academic life can find the placement in the university perplexing as they contend with administrative duties, periodic ,yet regular assessment of medical students, deficiency in formal teaching methods and difficulties in coping with both clinical work load and academic teaching. If a mentor is available from the outset, the mentee finds comfort and develops confidence and productivity is expected to increase with maturity and time.

Patience is fundamental to mentoring as both the mentor, who is often a senior faculty with his own

schedules and tasks and the mentee who may be a novice, will need to establish their relations and purpose. Leadership qualities will be put to the test especially when the mentee lacks maturity, is emotionally unstable and is deficient in both competence and commitment (D4 category).

Trust develops when the mentee can depend on the expected role of the mentor and finds help in problem solving, seeking advice, proceeding with research proposals, or mentoring others (medical students and nursing students).

The job of the mentor becomes easier when the mentee shows evidence of emotional maturity and is ahead of others as far as competency is concerned. The mentor is to take cognizance of the mentee who is highly competent in one field (research and writing) but would need mentoring on other fields like meeting timelines or has weaknesses in teaching.

Conclusions

Mentoring the clinician-educator poses several challenges as academic medicine requires stringent career development goals. The clinician who pursues a career in academic medicine multitasks as a physician, educator and has to perform administrative duties. Mentors have been seen to have enormous advantage in influencing development goals of mentee clinician educators in career advancement, research and scholastic writing. Effective mentorship in the clinical setting is required for facilitating the clinician-educator to pursue academic medicine and be an equally good role model in mentoring.

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