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Mentoring in medical education: A neglected essentiality

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Editorial

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The term "mentor" has its origins in Greek mythology, where Ulysses entrusted his son Telemachus to his friend for mentorship.[1] Various definitions have been used for mentorship which include professional support, personal support, a supportive relationship, reflective practice, and partnership for a common goal.[2] Mentorship has been defined as "a dynamic, reciprocal relationship in a work environment between an advanced career incumbent (mentor) and a beginner (protégé), aimed at the development of both."[3] In surgical disciples, the mantra is "see one, do one, teach one," and this can be aptly applied across all subjects and is an accepted form of mentorship.[4]

It has often been stated that, there was always the concept of mentorship in India in the form of *guru-shishya parampara.* However, it can best be termed as informal mentorship as we do not have access to any documents supporting the contrary. The gurus were choosy in picking their mentees. In recent times, in Indian medical schools, there is largely no formal mentorship program. Students imbibe characteristics of their role model as a part of a hidden curriculum. This however is not optimal as we have to ensure that the benefits of mentoring reach each and every medical student. The patients and society are also stakeholders and direct beneficiaries of mentorship programs. Often, a beginner left to treat patients alone does not only harm the patient but also harms himself as a result of loss of self-confidence and self-esteem. Hence mentoring and nurturing by advanced learners and facilitators has to be done within the organizational framework of every medical institution. It has to be structured and closely monitored, but does not have to be graded. By and large, the mentoring benefits the development of both mentors and mentees. Hence, it is needed today as there is a progressive deterioration in professionalism and ethics in the medical profession world over, as well as in India. Therefore, within the realm of medical education, greater emphasis is now being placed on structured outcome oriented mentorship in the Western countries,[5-7] as it promotes the acquisition of desirable competencies.[8]

Mentorship provides a mentee with greater clarity on strategies for self-improvement, helps them set their goals, make informed career choices, and get an opportunity to join new networks to expand their resource base. It also benefits the mentor by ensuring that they remain updated, develop relationships with their mentees and increase theirs as well as the organizational credibility.[8]

There are four phases of mentorship.[9] Phase 1 is the preparatory phase focusing on growth. During this period, mentees define their short/ long-term development objectives, evaluate their capabilities, and understand their aspirations. With their goal in mind, ideally, a mentee selects a mentor, but most often the mentor is allotted by the institution. A mentor should have sufficient experience, respect within the institution along with maturity, and within the Indian context, must be of the rank of at least an associate professor, but ideally a professor. Sensitivity has to be retained for gender and cultural diversity. Phase 2 is the negotiating phase where there is rapport building between the mentee and the mentor. After being alloted or having selected a mentor, the mentee and the mentor formally meet, get introduced and begin the process of breaking the ice. At this stage, both are uncertain about the

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future but since they have made an informed choice to enter into this relationship, their attitude is usually positive. However, the option of changing the mentor must always be given. Relationship building should not only revolve around career, education, knowledge and skills but also on personal hobbies, friends and family. To be effective, the mentor must explore the value base of the mentee and their goals in life. In Phase 3, there is an enabling of growth, where a formal structure is given with a discussion on the expected outcomes of the mentorship relationship and program. This phase is often called the contracting phase. The mentor-mentee can also define areas to be left out of such discussions. The most important part is building mutual trust and ensuring confidentiality. They may also develop a checklist to document their progess and whether they are moving on the desired path for mutual benefit. Meetings must be scheduled at least once a month. Based on the basic principles of ethics, they must ensure that no harm is done to either party. Phase 4 is coming to a closure. The mentor-mentee duo assess the value of partnership, identify areas of growth and learning and celebrate achievement of learning outcomes. Often such relationships continue lifelong.

In a review of 14 papers published between 2000-2008 on mentorship programs to provide career counselling, professionalism and develop research aptitude, one to one as well as group mentorship programs brought about desired outcomes.[6] Similarly, an audit of the mentorship program in the UK showed it to be an effective tool for enabling a transfer of desired clinical skills to students. It also made them more confident entrant practioners.[7]

There are various types of mentoring,[10] the most common being one-to-one mentorship. Even though this ensures individual attention, it is time consuming. There could be group mentoring, especially where there is a time and resource constrain. Openness, in group mentoring has the potential of greater benefit as collective knowledge is better than that of any one individual. One form of group mentoring is team mentoring, which can be used for a targeted program, as in sports. Peer mentoring can be practised by students and junior faculty through one to one or informal group process. In a modified version of mentoring, peer assisted learning with a facilitator resulted in improved learning and was well accepted by undergraduate students in a medical institute in India recently.[11] Online or e-mentoring is also practiced as it has flexibility, but both parties must be motivated and committed towards a common goal. An example of this is the programs run as Foundation for Advancement of International Medical Education and Research (FAIMER) through various institutions globally, as well as in India. A relatively recent concept of reverse mentoring is emerging where junior faculty with recent and advanced knowledge and skills impart them to senior counterparts. This usually happens during team work and endorses the formation of medical teams with a mix of senior, mid-level and junior faculty members. There is recent evidence of benefits of mentoring from Indian medical schools,[12] but more of such programs have to be initiated, monitored and documented. No single model can be endorsed at present, so there is scope for experimentation and innovation.

Mentoring, therefore, is a goal driven finite process. To be successful it has to be structured and documented. Lack of training for formal mentoring, as well as mentoring per se has perhaps contributed in its own unmeasurable way to poor acquisition of clinical skills in graduates and post graduates in India. Hence, leading and established medical institutions have to reflect and start or rejuvenate mentorship programs in different stages of medical graduate and post graduate program in India.

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