



Mentoring resident doctors

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Mentorship is a relationship akin to the apprentice-master dyad. It is a relationship characterised by an intense and global nature, extending over a long time. It covers both professional and personal issues and is aimed at the mentored person's development, with the mentor having the best interests of the mentored person at heart. Characteristically, it involves a relationship between an older (wiser) person and a younger (developing) person.

Traditionally, medical education has been regarded as an apprenticeship. The trainee works with a master who helps him/her to develop knowledge and skills. In the distant past, apprentices not only worked with their masters, they usually also lived with them (almost as one of the family), and they were certainly subject to the master's discipline.

Apprenticeship training in medicine can be seen as the era of mentoring in medicine. Subsequently, formal education has been grafted on to the experiential part of apprenticeship, leading to increasing standardisation and centralisation of the training process. Medical training followed the same path, and has moved further away from the traditional apprentice model, by focussing very intensely on the acquisition of knowledge. This extends beyond basic training through to the completion of specialist training, with the trainee having to pass examinations testing knowledge and skills.

While College membership or fellowship was once the result of an election of a candidate nominated by his/her mentor after a period in an apprentice role, our current practice is that election to fellowship occurs because the candidate has successfully passed a set of examinations after a period of training, with specified training experiences having been satisfied. Indeed, the satisfaction of the training requirements is largely time-based, although a succession of supervisors affirm that the trainee has performed to an at least adequate standard.

It is not uncommon for informal mentoring relationships to develop during training, as the trainee identifies a senior whose practice he/she wishes to emulate. Such informal mentoring occurs in many settings, with the drive to the establishment of the mentoring being sometimes from the mentor and at other times from the student. It tends to remain within the social and cultural niche of the student (including gender).

Issues for medical mentoring

Professionalism—Medical professionalism is a much talked about concept, yet there is probably no universal understanding of what is meant by the term. A commonly cited aspect of professionalism is the subordination of one's interests to the interests of the patient¹—at times reduced to financial self interest.² Sometimes the concept of the professional appears to be subsumed into the concept of the expert technician; therefore reducing the professional to someone with a set of skills and knowledge for sale.

This conception of the professional leads to the desire to have codes of ethics written *for* the professional as much as by professionals themselves. It also tends to explain the move to an increasingly rule-based code of ethics.

Being a professional is much more than being an expert technician. It means being a person of a certain sort, someone with a particular character. That is certainly the approach adopted by the virtue ethicists, who identify ethical behaviour with *phronesis* (practical wisdom) and with the display of the virtues of the profession. Aristotle regarded the virtues as the mean of a continuum between two extremes—both of which would be a vice. So, using the example of placing the interests of the patient above one's own, the virtuous doctor should occupy the middle ground between selfish disregard of the patient and self-sacrifice such that the patient (and potential patients) can no longer be helped.

The teaching of professionalism and of ethics is much talked about, and subject to many approaches. Didactic teaching offers the knowledge base that is important for the *phronimos* (the practically wise man) so that it allows him to build experience upon. The true *phronimos* needs to practice the virtues and to increasingly develop them over time—it is not part of practical wisdom that it is possible to be gained through theory alone.

Hence we return to the apprenticeship or mentorship model. The reason for arguing for mentorship, rather than leaving this to a succession of supervisors, is that much development of the specific virtues for excellent and ethical behaviour is dependent on modelling, guidance, and indeed nurturing. It is hard enough to establish a working relationship with a trainee within 6 months, let alone taking this further into the development of a mentoring relationship.

Furthermore, it is likely that the very task- and goal-orientated responsibilities of the clinical supervisor actually run counter to the mentoring relationship, which is more orientated towards the young person rather than his/her outputs. The concept is that, as the person develops through the mentoring process, he/she will modify his/her actions to enhance their nature and thereby produce better outcomes.

This may seem as if the supervisor should ideally act as mentor. There is no doubt that in many supervisory relationships in medicine there is a mentoring aspect. Many doctors reflect back on their supervisors (or at least some of them) with fondness and gratitude. Nevertheless, the key component of mentoring (of long duration) is negated by the 6-monthly rotations our trainees undergo.

The nature of current practice is such that mentoring occurs more by chance than by design, and is dependent upon the chance coinciding of the *phronimos* with the eager disciple.

Career choice—One of the reasons many doctors give for their choice of specialty training is the influence of an important senior practitioner in that specialty. It can be a parent. It may be a teacher at medical school who has inspired either personally or in the abstract. It may be a clinical teacher or supervisor. Occasionally, such a person may also become a mentor.

Mentoring during medical school training, and more definitively in the first postgraduate years, can assist young doctors clarify their career choices and can also assist in attracting trainees to specific areas of medical practice.

An area of major concern in the United States (US) is the numbers of women and 'minority' groups training in a specialty. For example, there are reports of being able to enhance the experience of training for women and for minority groups by providing mentors who are themselves successful women or minority members of the specialty. This is a case not only of being a role model; if it were that simple, then the existence of the person would be effective without there being a need for mentoring.

Mentoring adds in the opportunity to guide, to answer questions, to challenge, and to nurture the development of the trainee. Those aspects of the relationship cannot be hurried—time is needed to allow the relationship to develop, in the hope that out of that will come what Aristotle termed *eudaemonia* (or flourishing). This is the achievement over the person's life of the good after which we all strive; the achievement of excellence.

Diminution of stress—Being a resident doctor has always been stressful. Current employment conditions in New Zealand aim to reduce that stress and to protect from fatigue and the chance of error resulting from that fatigue. There has been a recent paper expressing the concern that a new regulation in the US prohibiting residents from working more than 80 hours in a week (and more than 24 hours continuously) may seriously interfere with the development of skills and of professionalism.³

While that extreme view is untenable, there does seem little doubt that there are problems faced by residents in meeting the requirements of training, in the sense of the breadth of experience, within a practicable timeframe. However, extending the hours of work, and decreasing the closeness of supervision, add to the stress experienced by the resident.

A mentoring relationship can help the resident deal with stress and also assist him/her in gaining the maximum benefit from the experience he/she has. A report from the United Kingdom (UK)⁴ showed that senior house officers (SHOs) experience psychological distress in proportion to their confidence. Other factors that increase stress are communication difficulties and organisational issues. These are all amenable to benefit from a mentoring approach, and are likely to be more helped by mentoring than by standard supervision.

A resident doctor who is feeling stressed (due either to workload or to problems related to knowledge and/or skills) may be anxious about confiding that to the supervisor whose report will have a significant impact on future employment opportunities. Additionally, the supervisor-trainee relationship is a relatively brief one, which may be perceived by the resident doctor as not supportive enough to foster the trust needed for safe exposure of difficulties.

A Nottingham (UK) survey⁵ found that 25% of SHOs reported an absence of feedback on work performance, and 25% also reported an absence of advice about career development. Over 75% believed that careers-counselling was essential. There was also an unmet need for counselling related to particular difficulties, with almost 50% of SHOs saying that they wanted this as well as regular performance appraisal.

The addition of mentoring to the supervision process in current practice, with appropriate strengthening of the supervisory requirements on the supervisors, will begin to meet some of these needs for guidance and support through the difficult formative years.

The mentoring relationship continues over several attachments and stages of development, allowing the mentor to focus on longer-term growth rather than the much shorter-term educative goals of supervision. The main precept for the mentor is that of having the best interests of the mentored person at heart.

Career development—Having the support of the right person, such as a referee or mentor, can help in career advancement. The mentor is able to ‘groom’ the protégé and assist him/her in developing what is needed for success. Ragins and Cotton⁶ reported that protégés of mentors were more successful in their careers than non-mentored individuals. Their report, which showed that informal-mentoring relationships were more successful than formal relationships, may be connected with a better fit being achieved in the informal, ‘voluntary on both sides’ relationships.

Informal mentoring relationships too often result in white men being the protégés of white men.⁷ As the protégés of (generally powerful and influential) white men tend to do considerably better in appointment to sought-after and highly-paid jobs, it is important that a mentorship programme is organised in such a way as to spread that influence more widely. Indeed, mentor protégés are generally better educated, earn more at a younger age, tend to follow a career path, and report high job satisfaction.⁸

Proposal for the future

Resident doctors will benefit greatly from having a mentor-protégé relationship with a senior colleague. Such a relationship is likely to help the resident doctor deal with the stresses experienced in training, to guide them in their career choice, and to assist in career development. Furthermore, the mentored doctor is more likely to achieve success in academic and clinical practice.

Frequent and informal mentoring relationships undoubtedly occur, varying from highly successful to relatively ineffective. A programme to develop mentorship will likely move more resident doctors towards the successful end.

There is debate surrounding informal versus formal mentoring programmes, rather than mentoring *per se*. As already mentioned, Ragins and Cotton⁶ found that protégés from informal mentoring were more successful than were those from formal programmes. This may reflect the choices made in informal relationships; that mentors tend to choose someone more like themselves. This, of course, will produce a better ‘fit’, which is necessary for the best outcomes.

However, despite the seemingly positive aspects to informal mentoring, their infrequency does mean that many young doctors who may benefit will miss out. Regarding the low numbers of women and ethnic minorities in some areas of medicine, informal mentorship will probably not change that. Therefore, establishment of a formal mentorship programme in all DHBs is advocated.

Senior doctors should be asked to volunteer as mentors—these doctors would be asked to fill the mentor’s role of ‘teaching, coaching, supporting, counselling, and sharing information with the protégé’.⁹ The doctors who volunteer for (and accept) this mentoring role, which is a significant addition to their current workload, are likely to benefit from training in the role.

Having a formalised mentorship programme will more readily permit the development of such training. It will also remove, or at least diminish, the possibility

of resistance to mentoring from the resident doctors who may perceive mentoring as a statement that they are failing somehow. Group mentorship may occur, provided that every individual willingly joins in the group, and has access to individual time with the mentor as and when needed or wanted.

Medical mentorship within the New Zealand district health board (DHB) structure would need the backing of the chief medical advisors. Both as a group and individually, the chief medical advisors are influential in the development of young doctors through their responsibility for various clinical and resource issues affecting training and career choice.

The chief medical advisors have the opportunity to be instrumental in the development of a mentorship culture, which will enhance the development of all younger colleagues. This should then help resolve some of the shortages of personnel in some specialties, and may also address the gender and ethnic mix.

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