EDUCATIONAL REVIEW

Perspectives in Mentorship & Mentoring Programs in Post-graduate Medical Education and Beyond: An Indian viewpoint

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Mentorship Programs have long been seen as an organizational approach for managing transition points in professional careers[1] Although unstructured, mentorship programs and mentor- mentee relationships have always existed in medical education in India. We still lack well-identified, formal state run, Mentorship planning in specialist training curriculum and continuing Professional development. From the studies retrieved in many reviews, there appears to be a paucity of research that has undertaken an in depth investigation into mentorship from the perspective of doctors. Hence, an attempt to shed light on this much needed cornerstone in Medical education for every Medical teacher.

History of mentoring:

The term 'mentor' and 'mentoring' have their origins in Greek mythology. Barondess (1995) provides an account of a mythical character from Homer's Odyssey set in ancient Greece. When Ulysses left his family to fight in the Trojan war he entrusted his infant son Telemachus to his friend. Barondess provides a useful, but brief description of how this mythical relationship developed and what its key characteristics were. He broadly categorises the key elements of the relationship as spiritual and pragmatic and these are themes that continue to run through the contemporary literature under the categories of personal and professional development in mentorship. [1]

Defining mentoring:

There are a variety of definitions in literature of mentorship and they contain common themes, which include: professional support, personal support, supportive relationship, reflective practice and a partnership based on common bonds or interests.

In the first systematic review of mentoring in the medical context undertaken by Sambunjak et al. (2006) and Jackson et al. (2003) both defined mentoring as "a dynamic, reciprocal relationship in a work environment between an advanced career incumbent (mentor) and a beginner (protégé), aimed at promoting the development of both". [1,2,3]

The definition proposed by the faculty mentoring committee at John Hopkins University, and cited by Berk et al (2004). Underplays the reciprocal nature of mentoring and suggests that mentoring is only concerned with providing guidance and support to promote the professional development of the mentee. They state that,' a mentoring relationship is one that may vary along a continuum from informal to formal or long-term to short-term, in which faculty with useful experience, knowledge, skills and/or wisdom offers advice, information, guidance, support or opportunity to another faculty member or student for that individual's professional development.'[1,4]

Characteristics of a mentor and mentee:

Research reports have listed some valuable characteristics of effective mentors (Bhagia & Tinsley, 2000; Grainger, 2002, Hesketh et al., 2003; Jackson et al., 2003; Levy et al., 2004). [5-9]

Strauss et al. (2013) bought into the forefront a few positive as well as negative traits in mentors and mentees and mentoring relationships. [10]

Components of a mentoring relationship:

A. Initiating a mentoring relationship

Mentoring can develop informally over time, from perhaps a friendship towards a mentoring commitment or it can be a formally assigned relationship. Studies have raised concerns about the formal assignment of two people to a mentoring relationship, which they may feel forced into. The perception was that if a mentee identified a potential candidate for a mentor and where there was the element of 'chemistry' between both parties that a more comfortable and effective relationship may develop. [11]

B. Structuring of the mentoring relationship

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The structure of a mentoring relationship is linked to gender, race, ethnic composition and the number of actors in the mentoring relationship[1]. Sambunjak et al. (2010) report that findings from five studies included in their review were inconclusive which suggest that matching pairs, on these structural elements were not viewed as essential. The sensitivity of the mentor may be more important than matching on any of these factors.[11]

C. Benefits to the mentoring relationship

A variety of studies have highlighted the benefits of formal mentorship programs. Studies by Benson et al. (2002), Pololi et al. (2002), Wingard et al. (2004), Kosoko-Lasaki et al. (2006) and in particular Kashiwagi and colleagues (2013) have all stated that' faculty retention appears to improve in systems with mentoring programs'[12-16]

Pololi et al. (2002) categorically stated that, it helped both mentors and mentees find greater satisfaction in their work and improved their understanding about the nature and expectations of academic medicine. Objective outcomes amongst these studies included better retention rates of, mentors and mentees into faculty, the number of successful nominations to professional societies and committees, research and academic achievements and promotions, awards and overseas placements.[13]

A similar research article by Steele et al. (2013) indicated that a positive mentoring experience during residency training provided a higher incentive to pursue an academic career. There was unanimous agreement among participants in the focus groups that having nurturing formalized mentoring programs promotes career development. [17]

Mentoring was perceived to have a positive impact on consultation skills, work relationships and teamwork. Mentors and mentees spoke about positive changes to their professional and personal confidence and morale in a Steven et al; (2008) study [18]

Models & Approaches to Mentoring Programs:

Varied arrays of models and phase approaches for mentorship programs are available, and are modified by states and Universities and sometimes individual institutes.

Models of mentoring:

1. Dyadic mentoring model

The basic principal approach here being, a 'dyadic mentoring approach' (senior-junior hierarchical delivery system). Characteristics such as power, dominance, dependency may tarnish the transparency of the mentoring relationship in this approach.[13]

2. Peer mentoring model

Medical educators who have studied peer (or near-peer) mentoring suggest that it is a feasible and perhaps more desirable alternative to traditional dyadic mentoring approaches (Woessner et al., 1998; Pololi et al.,2002). Participants identified their peers as 'collaborators' or 'colleagues' (implying a non-hierarchical relationship), while seeking shared insights, experiences, ideas, guidance, problem solving and support from them.[13,19]

3. Pyramidal mentoring model

Pressures on faculty time could be alleviated to a certain extent by creating a pyramidal system of mentoring. Such a model would entail a group of mentees at the bottom of the pyramid who can seek advice from a small group of peers a little higher in the pyramid with the more experienced, senior mentors overseeing and guiding all of them at the top of the pyramid. This pyramidal system would minimize the threat of the power relationship, yet offer the benefit of the valuable experience that senior faculty at the top of the pyramid possess. (Ramani & Gruppen et al 2006) [20]

Models of approach to mentoring:

Five phase approach model:

A popular approach pathway propagated in a report on a pioneering mentoring program by Buddeberg-Fisher et al. (2004) is the five-phase model. It includes forming (informing about career opportunities), storming (developing career plans), norming (focusing on career goals), performing (implementing career steps) and finalizing (evaluating career successes) as initiating steps to a successful mentoring relationship. [21]

Barriers to Mentorship: The Indian scenario and elsewhere

Lets face it. Although a lot of medical faculty members are stalwarts in their respective fields and good teachers in their own rights, not all of us may have the skill sets needed to be a mentor. One may even question what is the incentive it holds for a mentor, with all the time and hours of dedication put in to mold another professional's academic and medical career. In an Indian scenario barriers related to culture, religion, political views and gender might also pose a challenge.

A formal guide at the level of a Professor has always been assigned to each Post-graduate trainee in a Doctor of medicine/Surgery Degree in India. These are according to the mandatory norms required by the Medical Council of India. But besides guiding the dissertation undertaken, the needs of the trainee for further transition points in his professional career are not attended to, by all guides most of the time. One cannot

fail to mention one of the earliest studies on mentorship by Daloz (1986) here. He states that effective mentor–prote´ge´(e) relationships should balance three elements: support, challenge and a vision of the prote´ge´(e)'s future. [22]

No Support	Support
Regression	Growth
Stasis	Validation
Challenge	No Challenge

Figure 1: Support Versus Challenge
Source: Figure adapted from Daloz (1986).

What can be done now?

A lot of these barriers have been addressed by, Ramani & Gruppen et al 2006 in an article based on half-day workshop presented at the 11th Ottawa International Conference on Medical Education in Barcelona in 2004. They suggest a 12 essential tips approach to tackle these barriers grouped into three domains. [20]

Source: Ramani & Gruppen (2006)

The Indian scenario will probably need a path breaking facelift in the form of formal mentorship programs made mandatory by governing bodies and universities. As medical teachers we all need to recognize that the process of change will need to come from each of us to execute this necessary cogwheel in the machinery of medical education. With the wealth of knowledge and Evidence based practice experience passed down to generations in post-graduate medical education in India and inherent culture based respect for our elders & teachers, there is very little stopping India from implementing successful formal mentorship programs.

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