

The Mentor Case: A Proposed Model for Mentoring in Anaesthesia Departments.

PETER HOWE, MB, BS, FANZCA

Consultant Anaesthetist, Royal Children's Hospital, Melbourne

Peter Howe has been a consultant anaesthetist at the Royal Children's Hospital since 2000, and the Supervisor of Training since 2001. He has a particular interest in personality styles and their impact on communication, teaching and professional development.

INTRODUCTION

The practice of anaesthesia is a mixture of art and science. While our College deals admirably with scientific training, most of us learn the art of anaesthesia by modelling ourselves on senior colleagues whose work, manner and demeanor we admire.

In addition, lucky ones among us can think of a certain senior colleague who became a mentor. That person took us under their wing, provided timely advice and helped us address the complex choices that arise at the end of training and in the early years of consultant practice.

The concept of mentoring comes from the Greek myth of Odysseus and his son Telemachus. When Odysseus left to fight the Trojan War, he asked his friend Mentor to guide Telemachus from youth to manhood. From this beginning, mentoring has come to embody a relationship where an older or more senior person acts as advisor, teacher, coach and/or protector to a junior colleague.

Most anaesthetic consultants form helping relationships with trainees and junior colleagues from time to time. We might see an obvious area for improvement, but don't feel that we have either the skills or the colleague's permission to get more involved, deepen the relationship and provide detailed, challenging and at times negative feedback. An opportunity is thus lost – not only to help our junior colleague, but also to extend ourselves and increase our feeling of relevance to those starting their careers.

This article will define mentoring and examine evidence that it is of benefit. It will propose a structure for organising a mentoring program within an anaesthetic department and suggest strategies that mentors might employ. It will emphasise that the only essential attribute of a mentor is a willingness to listen, be genuine and appreciate the mentee for who they are. Finally, it will introduce a new tool for use by mentors, "The Bolton Box", which is used by the author at the Royal Children's Hospital in Melbourne ("RCH").

If we are interested in the wellbeing of our junior colleagues, and are prepared to take our worth as a wise and trustworthy advisor seriously, then with a relatively small amount of effort we can set up a modest program and become mentors in a short space of time. The most surprising and pleasing outcome may be that we derive benefit as well.

DEFINING THE ROLES OF PEOPLE WHO HELP US

In 1998, the U.K. Standing Committee on Postgraduate Medical and Dental Education defined mentoring as a "process whereby an experienced, highly regarded, empathic person (the mentor) guides another individual (the mentee) in the development and examination of their own ideas, learning and personal and professional development. The mentor, who often, but not necessarily, works in the same organization or field as the mentee, achieves this by listening and talking in confidence to the mentee"¹.

People who help us may at different times act as teacher, role model, supervisor, mentor or counsellor. Clinical teachers teach us material relevant to our work. Their style, method and depth of teaching may be varied to suit the trainee's level of competence, but the content taught to one trainee is usually the same as would be taught to another. Role models teach us to be like them, whether or not they are conscious of their influence. Mentors teach us to identify issues that are important to us, whether or not those issues are important to the mentor. The mentor helps us become the person we want to be, whether or not that happens to be like the mentor.

Table 1: People who teach

Clinical teachers	Role models	Mentors
<ul style="list-style-type: none"> teach us about their field of expertise content usually similar for all students 	<ul style="list-style-type: none"> teach us to be like them may be unaware that they are teaching 	<ul style="list-style-type: none"> teach us to reach our potential content specific to each mentee

Many people are available to trainees with issues to discuss. A supervisor of training is responsible for a trainee's wellbeing, but is also responsible to his or her department, college, profession and the community at large. Trainees may feel that revealing a problem to a supervisor will decrease their future employment prospects. If a trainee wants time off to address a problem, a supervisor has a potential conflict between helping the trainee and staffing issues within the department. If a trainee seeks advice for career advancement, it may be unfair for an authority figure to help one trainee more than another. Ideally, mentors are outside the mentee's professional hierarchy, so that such problems can be discussed without generating conflicts of interest.

A counsellor counsels. The British Association of Counsellors defines counselling as a professional relationship where the counsellor helps the client "explore, discover and clarify ways of living in a more satisfying and resourceful manner"². This is very similar to the definition of mentoring, and supervisors and mentors often use counselling skills such as active and impartial listening, problem solving and crisis support.

It is thus difficult to know where the use of counselling skills ends and acting as a counsellor starts. One difference is the nature of the contract between the parties. A supervisor usually instigates a mentoring program; the focus is usually on professional development, and a mentor and a mentee are wise to have some sort of agreement allowing the mentor to broach subjects beyond academic and clinical material. Formal counselling usually focuses on personal development, and is usually more disciplined and confidential than a friendship or mentoring relationship. The client, who is often distressed, confused and potentially vulnerable, usually initiates the relationship.

In establishing a mentoring program, we are not starting a counselling service. If issues arise that are beyond the skills of the mentor, then an appropriate referral should be made, as it would be for any other health condition. Both parties may be damaged if the counselling process moves into areas beyond the training or competence of the helper².

Table 2: People who help solve problems

Supervisor of training	Mentor	Counsellor
<ul style="list-style-type: none"> responsible for trainee's well-being focus on work issues potential conflict of interest 	<ul style="list-style-type: none"> helps mentee reach potential focus on professional issues little conflict of interest 	<ul style="list-style-type: none"> helps client reach potential focus on personal issues client may be vulnerable no conflict of interest

IS THERE EVIDENCE THAT MENTORING HELPS THE MENTEE?

In the field of education, mentoring has been shown to offer numerous, far-reaching benefits, particularly professional and emotional support and career affirmation for junior teachers³. Mentoring is recognized as a catalyst for career successes in the business community⁴, but the specific components of the mentoring relationship that lead to an individual's success are difficult to identify. Many motivated and self-directed individuals seek out their own mentors, and these qualities may be more a factor than the mentoring itself.

Mentoring is also an important component of academic medicine. Mentors help doctors in training to make career choices and manage the stresses of working with the sick. Many

clinicians, researchers and practitioners, not to mention mentees, find that the relationship itself is of great importance, irrespective of the outcome; yet without evidence for its benefit, it may be difficult to justify spending time mentoring that could be spent on clinical, administrative, research or teaching duties.

A review of 82 articles published between 1995 and 2002 relating to mentoring in medical contexts identified several positive outcomes, including personal growth, networking and increased job satisfaction. The authors noted that most mentoring is informal and confidential, which limits the quality and quantity of research¹.

A recent systematic review of mentoring in academic medicine sought to evaluate all available evidence about the prevalence of mentorship and its relationship to career development⁵. The researchers performed an extensive search of MEDLINE, Current Contents, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Cochrane Central Register of Controlled Trials, PsycINFO and Scopus databases from the earliest available date to May 2006. They identified "all studies evaluating the effect of mentoring on career choices and academic advancement among medical students and physicians".

The researchers identified 39 studies and found 36 to have methodological limitations. 34 were cross-sectional surveys, with varying response rates and small sample sizes. Few studies had control groups and even fewer measured the effect of an intervention. Only 5 studies reported whether the mentor was allocated to or chosen by the mentee. Limitations notwithstanding, there were many interesting findings.

In several studies, mentees rated the importance of mentorship. 95% of an adolescent medicine faculty described their mentor as important to them; 16% of a group of child psychiatrists identified mentors as the single most important aspect of their training experience, and faculty members of 24 US medical schools who had mentors had significantly higher career satisfaction scores than those without mentors.

A study from the Stanford University Radiology Department described the evaluation of junior faculty members before and after a voluntary mentoring program. Performance in research had improved in 52% of participants, teaching had improved in 26% and patient care in 6%. A study of junior faculty at the University of California San Diego before and after a structured mentoring program showed significantly increased confidence in professional development, education and administration, as assessed by participants themselves. Neither study had controls for comparison.

10 studies compared aspects of mentorship between men and women. There was an impression that women in particular considered the lack of appropriate mentorship as a major obstacle to a successful career. It did not seem to matter whether the mentor was a male or female. 21% of women faculty at a US medical school rated departmental mentoring as their most important resource.

The most readily demonstrable benefit of mentoring was in research, where a mentor's focus is usually to help the mentee develop a project, seek funding and prepare papers for publication. 21 studies described the impact of mentoring on research development and productivity. Survey respondents who had a mentor produced more publications, received more grants and were more likely to complete their thesis - although in one study, 32% of women and 10% of men reported that mentors used the mentee's work to advance the mentor's own career. Lack of mentorship was identified as a specific barrier to completing scholarly projects and publication.

The researchers concluded that although mentoring is perceived as an important part of academic medicine, the evidence to support this perception is not strong. Without control groups, the benefit of mentoring cannot be quantified. Furthermore, there is no evidence about how to allocate a mentor, how often to meet, what subjects to address and how intensely to address them.

Nevertheless, they observed that mentoring does have an effect on personal development, career choice and research productivity, and suggested that mentoring programs should focus on these areas.

DOES MENTORING HELP THE MENTOR?

We do not know how Mentor felt, but it is quite possible that he was honoured by the trust of Ulysses and enjoyed his close association with Telemachus. Modern day mentors often experience these emotions.

A review of mentoring in education found that rewards associated with mentoring typically come from professional and personal development, particularly as mentors reflect on their own beliefs and practices³. Negative aspects included personality clashes with the mentee, extra responsibility that was not recognized by others, and the potential for tension if career advancement was sought by many mentees, but was available to few.

Charles Healy, a prominent educational researcher, defines mentoring as “a dynamic, reciprocal relationship in a work environment between an advanced career incumbent (mentor) and a beginner (protégé), aimed at promoting the career development of both”⁶. Healy’s emphasis is not only on the protégé, whose goal is to move from understudy to colleague, but also on the benefits for the mentor. He argues that the potential for development of the mentor is an integral part of the mentoring relationship, rather than a fortunate by-product. His definition is influenced by the work of Erik Erikson, the German psychologist known for coining the phrase “identity crisis”. Healy argues that the mentor has an opportunity to transcend what Erikson described as the “stagnating self-preoccupation of mid-life...by exercising an instinctual drive to create and care for new life”⁶. A mentoring relationship with a junior colleague may make the mentor feel more relevant, and the energy and enthusiasm of the mentee may encourage the mentor to undertake new projects or reconsider established habits and opinions.

Healy contends that “career development in professional and managerial fields occurs as workers successfully redefine their roles, assuming capabilities such as specialist, troubleshooter, consultant, leader and mentor”⁶. A mentoring interview presents an opportunity to develop our communication skills and try new techniques, in the same way as we might read about and then try a new regional block. A long term mentoring relationship helps us to become more aware of our own values and motivations, which in turn enhances our leadership capabilities⁷.

FIVE ISSUES TO CONSIDER BEFORE STARTING A MENTORING SYSTEM

1. *Decide who should be the mentor and who should be offered mentoring.*

In a small department, there may not be enough people outside the departmental hierarchy to act as mentors. A mentoring relationship takes time to develop; in large departments with many trainees on relatively short rotations, resources may be better spent in other ways, such as supervision and teaching. At RCH, the mentoring program focuses on overseas and provisional fellows, who commonly visit the department for a year, rather than registrars who rotate for four months.

Consultants who know the public hospital system but are not part of the departmental hierarchy, such as those who do public sessions but work predominantly in private practice, may be the best placed of all to be mentors. They might meet a junior trainee in a public hospital, who then does an occasional session with them in private throughout their training. Such models are under consideration by the Australian Society of Anaesthetists.

2. *Determine if the program is to be voluntary or obligatory.*

If the participants are not obliged to participate, then one would hope that a sense of hierarchy between mentor and mentee is minimised. Nevertheless, there is always a danger that those who choose not to participate might be those who would benefit the most. At RCH, provisional and overseas fellows are encouraged, but not obliged, to participate.

3. *Decide whether mentors will be chosen by the mentee or allocated by a supervisor.*

It is reasonable to suppose that mentees will choose mentors with whom they are likely to develop rapport. If they have a particular interest, especially research, it may be appropriate either to allocate a mentor or let them know of consultants who have similar skills and interests. At RCH, participants are given a list of consultants who have volunteered to be mentors, and asked to approach someone from the list.

4. *Ensure that every mentee has a structured interview with their mentor, not just those who are perceived to be having problems.*

Intend that the interview not be seen as an assessment, but rather as non-threatening and hopefully enjoyable discussion to ensure that the mentee’s job is progressing well. The interview does present an opportunity to address perceived problems, but interviewing

everybody avoids awkward “come into my office” interactions and the defensive mood that commonly follows. At RCH, mentors and mentees meet informally at the start of the rotation to get to know each other and clarify the mentee’s goals from the rotation; the structured interview is held mid-term, so that there is enough time to act on issues that arise.

5. *Discuss confidentiality.*

Emphasize that the mentor is interested in the mentee’s personal and professional development as well as simply their performance in their current job, but also that the mentee is under no obligation to discuss personal issues. At RCH, everything discussed between mentor and mentee remains confidential except where legislation dictates otherwise, such as instances of sexual harassment or workplace bullying. This is explained as part of the fellow’s orientation to the department.

WHAT SKILLS DO I NEED TO START MENTORING?

The only important skill of a mentor is to be able to communicate clearly with the mentee. Professional colleges and medical defence organisations recognise the clinical and medico-legal advantages of clear communication, and often present courses where communication skills are taught. A mentoring interview is an ideal opportunity to practise these skills.

The influential American psychologist Carl Rogers was a founder of the humanistic approach to psychology, where the counsellor strives to understand the world from the client’s perspective. In his lecture “Experiences in communication”, he describes the importance of “a sensitive ability to hear, and the deep satisfaction of being heard”⁸. He relates instances from school where a child would ask the teacher a question and the teacher would give a perfectly good answer - to a completely different question. “My reaction was: ‘But you didn’t hear him!’ I felt a sort of childish despair at the lack of communication that was – and is – so common.”

Rogers focuses on three areas that are relevant to mentors:

1. *Listen!*

Effective listening can be practiced and learned. Rogers explains the value of listening without judging, diagnosing, appraising or evaluating. As listeners, we can let the speaker know that we have heard them by seeking clarification where necessary, then summarizing and confirming that our summary is accurate. As we listen, we might make statements that demonstrate empathy, which Rogers defines as “sensing a client’s inner world and communicating that sensing”.

It is not necessary for the mentor to be ready with a clever response, and if we catch ourselves formulating and rehearsing such a response, we might realise that we have stopped listening from that point onwards. It is often enough simply to hear someone and let them know that they have been heard.

2. *Be real.*

There is no need for mentors to hide behind a façade of wisdom and pretend to know the answer to every problem that might arise. We can usually recognise when someone is trying to impress us and say the right thing. By not trying to impress the mentee, we may engender the same authenticity in the mentee, and thus improve the directness and honesty of the communication. Rogers describes this process as achieving “congruence”.

3. *Appreciate, not manipulate!*

Rogers reminds himself to appreciate people in the same non-judgemental way that he might appreciate a sunset, a process he describes as “unconditional positive regard”. “I don’t find myself saying ‘Soften the orange a little on the right hand corner, and put a bit more purple along the base...I watch with awe as it unfolds.” He describes a sense of relief in spending less time trying to control or change others⁸.

We can start to learn this process by giving positive feedback. For feedback to be genuine, we need to observe the mentee and notice something that really does impress us, rather than make something up.

OFFERING CONSTRUCTIVE CRITICISM

Many of us set high standards for ourselves. We may feel little elation when we achieve our standards, but great dismay if we fail to meet them, even if only marginally. We may barely hear praise that comes our way, automatically responding in an understated Australian way that "it was nothing", but we may be very sensitive to criticism, especially if it comes from a colleague.

In a mentoring interview, a mentee may be quite taken aback by one criticism, and one, two or even ten accompanying items of praise may barely be heard in comparison. The time-honoured technique of sandwiching a negative between two positives thus often does not work – the mentor may never get to the second positive!

A mentor who is about to deliver negative feedback might be wise to first consider if it really needs to be said. Was the issue the result of a personality clash that may not occur again? Is it a subjective impression backed up by hearsay, rather than a discrete event that can be described objectively? If in doubt, it might be wise to say nothing or discuss it with a wise colleague before proceeding.

If a point needs to be made – and repeated subjective observations can have validity⁷ – then it might be possible to bring up the issue as a point for discussion rather than as what might be interpreted as an accusation. This is where the Bolton Box is potentially of great use.

STRUCTURING AN INTERVIEW USING "THE BOLTON BOX"

The Bolton Box was conceptualised by Dr. Chris Bolton, as has been developed and put into practice by the author over the past five years. It consists of a 3x3 table that is filled in by the mentee during the mid-term interview with the mentor (Appendix 1).

Column I lists aspects of the mentee's professional and personal life, grouped as "Skills/Attributes", "Your Job" and "Life Away From Work". Each heading has a series of subheadings, which act as prompts for discussion. Column II represents the situation at present, and column III represents a time perhaps five years ahead.

The first part of the interview addresses column II. The mentee is invited to list his or her skills and attributes in section IIa. The broad range of prompts sometimes draws attention away from any one apparent deficit that the mentee may be focusing on. The simple task of documenting and acknowledging positive attributes can be helpful.

In section IIb, the mentee describes important parts of his or her job. This might highlight good things the mentee is doing that are not often acknowledged. It also creates an opportunity to compare the mentee's job with his or her skills. A perception that one's skills are not sufficient to manage one's job is a powerful source of stress. If the perception is incorrect, the mentee may require reassurance. If the mentee's skills really are inadequate for the current role, then extra training or a change of workload might be discussed.

If the mentee's skills are at a higher level than his or her current role demands, the mentee may be frustrated. Many RCH fellows have completed their training, but are still sharing a roster and a pay scale with registrars. The ensuing conversation might focus on ways to manage the situation, such as teaching junior trainees, performing more complex work – or even resigning and finding a post as a consultant! The mentor's job is to support the mentee, not run the department.

Section IIc invites comment about the mentee's home life. The mentor might begin by asking if the mentee has enough time and energy to pursue other interests, given the demands of their current role. The mentee is not obliged to talk about his or her home life, but by this stage the rapport between the two may be such that the mentee is only too eager to reveal something that is a source of concern. Registrars preparing for examinations often reveal the enormous stress they are experiencing, in a way that might look like failure to cope if revealed in another context. Provisional fellows have often put their personal life on hold while they establish their career, and clarifying the issues that are being experienced can be very helpful. Once more, listening and summarising what has been said may be all that is required.

The mentor might then lead the conversation to contemplation of a readily imagined time in the future. If the mentee wants a certain job, then a description is written in section IIIb. If certain skills or attributes seem necessary to get that job, then these are discussed and listed in section IIIa; these might then serve as a focus for study or experience in the next few years. If the

mentee is planning to take time off to have children, but then return part time to a certain type of work, then these issues are put in the appropriate sections, and the type of experience to obtain in the short term can be discussed. All the information in the Box has come from the mentee; the mentor is simply providing a summary of what has been said, and leading the conversation to areas of relevance.

The Bolton Box can be used to discuss areas of perceived poor performance in a potentially non-threatening manner. For example:

* A trainee who had been accused of panicking in stressful situations was led to discuss his current appraisal of his communication skills, and to consider where he would like those skills to be in five years. The conversation led to a positive discussion of communicating in a crisis, without needing to deliver negative feedback.

* A senior fellow who never asked for help or advice was thought by many consultants to be arrogant. During a mentoring interview, she described how she liked to concentrate on the task at hand without chatting. The discussion led to how she might develop her leadership skills, which she described as very poor; a strategy emerged that she would practise explaining her plan to those who worked with her. Her performance in this area subsequently improved, again without negative feedback.

CONCLUSION

Mentoring is already a part of our role as medical professionals. Many of us have had valuable experiences as a mentor and as a mentee. There is evidence that mentoring is considered important by mentees, especially in the areas of research, professional development and choice of career.

Mentoring requires nothing more than a mentor who is willing to listen, be real and appreciate that the mentee is different to the mentor. There is no need to feel pressure to come up with incisive solutions or to counsel mentees in distress. The mentor is advised to think carefully and perhaps seek a second opinion before delivering negative feedback.

The Bolton Box is a simple tool that gives a non-threatening structure to an interview between mentor and mentee. It enables the mentor to show the mentee that they have been heard, and potentially enables the mentor to raise sensitive topics as part of a broad discussion. It presents the mentee's own words back to them in a way that may initiate new insights, connections and conclusions.

Establishing a mentoring program has the potential to make mentees feel valued and to teach mentors to communicate more effectively. Although there is little evidence of a quantifiable outcome from mentoring, it is possible that the process is just as important as the result.

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Appendix

<p>Ia <u>SKILLS/ ATTRIBUTES:</u></p> <p>Technical</p> <p>Knowledge</p> <p>Research</p> <p>Teaching</p> <p>Communication</p> <p>Leadership</p>	<p>Ila</p>	<p>IIla</p>
<p>Ib <u>YOUR JOB:</u></p> <p>Core workload</p> <p>Administration</p> <p>Research</p> <p>Teaching</p> <p>Leadership</p>	<p>IIb</p>	<p>IIlb</p>
<p>Ic <u>LIFE AWAY FROM WORK:</u></p> <p>Health</p> <ul style="list-style-type: none"> * Physical * Emotional * Psychological * Spiritual <p>Family</p> <p>Money</p>	<p>IIc</p>	<p>IIlc</p>