Research on mentoring in academic medicine is limited, with great variation in how the concept of mentoring is defined and with more attention paid to outcomes rather than the process of mentoring. One notable exception documents the process of effective mentoring by adopting a case study approach. Nationally, one-third to one-half of faculty report being mentored, but reported surveys neither differentiate informal from formal mentoring experiences, nor document the longevity of the mentoring process. Nevertheless, mentoring has been shown to contribute to an individual’s career development in academic medicine and other fields, particularly in the areas of research, career satisfaction, and perceived institutional support. The mentoring process provides a means by which junior faculty can develop professional academic skills including career management, knowledge about academic medicine, and collegial networking. Mentoring in research and academic development may be particularly important to new medical faculty, who often find themselves inadequately prepared for academic careers.

The changing nature of the current health care environment, increased clinical and administrative responsibilities, reductions in time and collegial support for scholarly activity and teaching, and a lack of access to mentors can hinder faculty scholarly productivity and career satisfaction, and may result in attrition from academe. Currently, 37% to 47% of physicians experience burnout.

Effective mentoring may help faculty increase career satisfaction and productivity and reduce their risk for burn-out.

Dunnington’s question, “Where have all the mentors gone?” resonates for many today in academic medicine. Recent changes in medicine are transforming clinical practice, research, education, and thus mentoring practices. Increased pressure to be “clinically productive” impacts negatively on the availability of mentors and their ultimate willingness to remain in academe. Potential mentors who are uncertain about what successful mentoring entails may be reluctant to take on the responsibility and have little access to mentor training.

A decline in the number of clinical research faculty and the consequent reduction in the availability of research mentors in academic medicine has resulted in fewer junior faculty who are well prepared as clinical researchers. Although a long-standing legacy of informal mentoring has served as a primary method of professional socialization for faculty in academic medicine, health care specialties that have traditionally focused on clinical practice and service face a dearth of senior mentors to assist junior faculty as academicians. In academic General Internal Medicine, for example, with only 11% of faculty as full professors, 21% at the associate professor, and 58% at the assistant professor levels (SJIM meeting 2003, Mentoring Precourse), it is unlikely that all junior faculty could be assigned a senior mentor. Additionally, a division chief may find conflict of interest in his or her roles as both guardian of the division and facilitator of a junior faculty member’s professional aspirations. Thus, although senior faculty can and do make significant and valued contributions to the professional growth of junior faculty, such mentoring has become increasingly scarce.

The effective mentoring relationship facilitates the formulation and “realization of a person’s own dream” through an evolution of personal growth and development. Rather than relying on a dyadic relationship, the mentoring paradigm that we propose is located in a group process characterized by non-hierarchical peer relationships, protégé empowerment, and self-direction. This reflective process involves the self-identification of personal and professional goals that are consistent with an individual’s personal values.

Types of dyadic mentoring: “informal” and “formal”

The notion of a senior professional promoting the career of a junior protégé(e) has shaped the development of mentoring...
to model desired behaviors and attitudes for their juniors. Most people equate mentoring with this traditional dyadic model. Informal mentoring occurs serendipitously when 2 individuals are drawn together by mutual interests and appeal, resulting in a kind of “spontaneous or accidental mentoring [that] almost always works.” This type of mentoring is characterized by a long-term, mutually satisfying relationship that is not initiated, managed, or structured by an institution or organization. Hallmarks of the relationship are support, mutual respect, and compatibility. Access to informal mentoring occurs only for a minority of particularly fortunate faculty and may be especially difficult to attain for those who tend to be marginalized, including women. Since women now have equal access to medical schools and currently comprise about a quarter of medical faculty, the issue of mentoring for women becomes critical for the profession. Mentoring has been suggested as a way of addressing women’s lack of advancement in academic medicine.  

Although informal mentoring provides a more effective mentoring model, the recognition that many faculty lack mentors has led institutions to increasingly implement formal mentoring programs. Unlike informal mentoring, formal mentorship is planned, often institutionally supported or mandated, and is somewhat reminiscent of a “blind date” or “arranged marriage.” It involves the assignment of a protégé to a mentor, with the (often-unrealized) intention of somehow fostering the quality and kind of relationship seen in informal mentoring. Power and status disparities characterize these relationships, with the protégé typically having less of these attributes.  

THE BENEFITS OF MENTORING

In the best of circumstances, the process of mentoring is mutually beneficial to both mentors and protégés in ways that include personal and career growth. Mentors often find themselves professionally stimulated, personally enriched and perhaps rejuvenated, and, as proposed by Erickson, derive satisfaction from this activity during the developmental stage of generativity. Similarly, Levinson et al. recognized mentoring as a developmental life stage, a time in which seasoned professionals give back to their professions. Those who are mentored are likely to continue the legacy of mentoring with their own students and junior colleagues.  

THE RISKS OF MENTORING

Mentoring is often assumed to be a universally positive experience for mentors and protégés in ways that include personal and career growth. Mentors often find themselves professionally stimulated, personally enriched and perhaps rejuvenated, and, as proposed by Erickson, derive satisfaction from this activity during the developmental stage of generativity. Similarly, Levinson et al. recognized mentoring as a developmental life stage, a time in which seasoned professionals give back to their professions. Those who are mentored are likely to continue the legacy of mentoring with their own students and junior colleagues.

LESSONS LEARNED FROM OBSERVING MENTORING PROGRAMS

In 1998, we were funded by the U.S. Department of Health and Human Services Office on Women’s Health (OWH) as a National Center of Leadership in Academic Medicine, charged with developing model mentoring programs for faculty with the goals of career advancement of junior faculty and gender equity in academic medicine. We designed, implemented, and evaluated 2 different model mentoring programs and a mentor training program, and had the opportunity to study carefully how medical faculty experienced the mentoring process. In this paper, brief reports of the dyadic program and Collaborative Mentoring Program (CMP) are offered; a detailed description and evaluation of the CMP has been published.  

The Dyadic Mentoring Program

The formal dyadic Personal Mentoring Program (PMP) paired a junior faculty member with a senior faculty mentor in a one-to-one mentoring relationship for 2 years. The matching of protégés and mentor was based on protégé preferences. The mentor–protégé dyads were expected to meet for an hour at least monthly during a 2-year period and maintain communication with one another via e-mail. Concurrently, mentors voluntarily engaged in a Mentoring Skills Program that provided them with skill development workshops, materials to use with their protégés, and opportunities to process their mentoring experiences with one another.

Consistent with observations from other formal dyadic mentoring programs, outcomes of the PMP program varied considerably. Qualitative program evaluation data revealed that protégés held a complexity of both positive and negative views about their mentorship experiences. Positive outcomes reported by some protégés suggested that at least some mentors approached Bhagia and Tinsley’s ideal: someone who inspires, supports, and invests in the protégé while providing psychosocial and career support. Other protégés, however, characterized mentorship as “superficial,” “exploitive,” “mediocre,” or “nonexistent.” Four of 11 participants reported that they were not able to establish and maintain a positive one-to-one relationship for 2 years with their mentor.

Protégés and mentors in the formal program cited finding time for mentoring as a persistent and serious difficulty despite their voluntary enrollment in the program. An inability to find time to meet for 1 hour each month raises questions about the nature of the mentoring relationship and protégés’
continuing uncertainty about its helpfulness and value. As Jackson et al. suggest, effective mentoring requires “a certain chemistry” between those involved. Although some protegés embraced their mentoring relationships and almost all were able to derive some benefit from the experience, several protegés acknowledged that their mentoring relationship felt forced and artificial, primarily as a consequence of, in the words of one protegé, “taking 2 people and sticking them together.”

Collaborative Monitoring Program

The CMP provided a facilitated group peer mentoring experience and skill development for junior faculty over an 8-month period. Beginning with an intensive 3-day session, the protegés continued together for 6 monthly day-long sessions. The program was structured as follows: (1) formulation of an academic development plan, (2) skills development in areas essential for advancement in academic medicine, and (3) a scholarly writing program.

The group was facilitated by the program director (L. F.), with the involvement of an additional cofacilitator for some of the sessions. The role of the facilitator was to ensure a safe and respectful learning environment, foster peer collaboration, and redirect the group to draw upon their own experiences and reactions to address each other’s needs and concerns. This was in contrast to more traditional mentoring practices where mentors typically share personal solutions or experience and offer advice. In the CMP program, participants came to recognize, value, and ultimately rely upon the wisdom and diverse expertise of their peers. Whereas the PMP was modeled on the familiar dyadic framework of mentoring, the CMP course was modeled on adult learning theory, theories of adult development, and the concepts of Carl Rogers, Friere’s concept of “praxis,” and on theory related to small-group dynamics.

CMP evaluation data highlighted the critical nature of a supportive learning environment. Learning outcomes included the following: (1) identification of their own core values; (2) the identification of short- and long-term career goals based on these core values; (3) the development of close collaborative relationships; (4) skill development; and (5) improved job satisfaction linked in part to their decision to remain in academic medicine. Participants described a sense of empowerment and personal transformation. Program attendance was excellent (89%), in contrast to the insuperable scheduling difficulties reported in the PMP.

PERSPECTIVE

Given the potential that effective mentoring has for facilitating career and personal success and satisfaction, the inadequate numbers of “informal” mentoring opportunities, the difficulties of implementing widespread effective formal mentoring programs, and the drawbacks and unpredictability of formal dyadic mentoring we propose a reconsideration of traditionally held views of mentoring. We seek additional mentoring models for medical faculty that can predictability and effectively meet the needs of diverse faculty groups. Our perspectives on mentoring are based on the research literature and on what we have learned through observing and documenting mentoring outcomes. Although long-term outcomes are not yet available, findings from the projects described here briefly contribute to a reenvisioning of the scope and structure of the mentoring process.

Everyone can benefit from mentoring in important ways, regardless of status, position, or level of expertise. The most beneficial forms of mentoring arise in the context of positive relationships and the creation of trustworthy, nurturing environments that facilitate learning and the open expression of personal concerns. It is within these environments that individuals can engage in identifying and addressing their core values, priorities, and learning needs. Additionally, mentoring may be particularly critical for the success and advancement of those less likely to be included in senior and leadership roles such as women and underrepresented minority faculty members. These nontraditional groups may be better served by nontraditional mentoring models.

Designing mentoring programs based on strategies and attributes that are known to facilitate relationship building and personal empowerment, that include structured experiential learning for skill development, and that draw on the richness of groups of individuals working collaboratively has great potential to more reliably and effectively meet the needs of faculty in academic medicine. Formal peer group mentoring reliably supports enhanced relationship development, avoids the misuse of power, compensates for the dearth of appropriately trained and willing senior mentors, and provides process and mentoring training.

We concur with Daloz that the many limitations associated with traditional mentoring are related to a failure of the mentoring dyad to move beyond an initially hierarchical relationship to one that is more egalitarian and complementary. The implied superior knowledge of mentors may be disempowering and restrictive for protegés, and less satisfying for mentors. The equalization of power in peer mentoring parallels relationships between physicians and patients in patient-centered practice, and between teachers and learners in learner-centered education.

Consistent with Erickson’s developmental stage of generativity, a worthy imperative for mentoring often emanates from faculty. Senior-level faculty may have a tendency to discount collaborative group peer mentoring models for junior faculty as these do not reflect their own altruistic motivations to mentor. Ideally, we need a structure that honors the altruism of senior faculty and utilizes the benefits and opportunities that this experienced group can offer. Such a structure could serve in conjunction with collaborative peer group efforts. In addition, the needs of senior faculty are not frequently addressed. In the context of the mentor training program implemented, for example, we found that senior faculty identified their own peer group experience as the most valued outcome of their training in mentoring.

Facilitated peer group mentoring offers significant benefits to participants, including empowerment; an absence of power differential; the involvement of multiple areas of expertise; mutuality; training for mentoring; and the development of personal awareness. We observed the program’s positive impact on collegiality and sense of belonging in a medical school, faculty retention, contributions to institutional goals, and the subsequent assumption of leadership roles by faculty participants. Because of the promise that this mentoring process holds, further research and evaluation of group peer mentoring in academic medicine is needed. An expanded vision of mentoring as a collaborative peer group process does not ne-
gate or diminish the value of informal dyadic mentoring; rather, it adds another dimension to the mentoring process and one that provides an effective, accessible mentoring opportunity for all faculty, as they strive to achieve their professional goals.

Mentoring programs in academia must more effectively address institutional and departmental needs for faculty retention and success; provide for the needs of diverse persons; address the issue of having very few senior faculty, both men and women, to mentor junior faculty; and extend the benefit of mentoring to midlevel and senior faculty members. Effective mentoring programs may be instrumental in addressing not only professional development needs but may also result in reduced burnout and increased physician retention. Such programs serve as a means of promoting physician well-being and contributing to physicians’ ability to fulfill their life dreams.

We thank all the faculty participants who volunteered for our demonstration programs and from whom we have learned so much. We are also grateful to Drs. Saralyn Mark and Wanda Jones of the Office on Women’s Health (OWH), U.S. Department of Health and Human Services (DHHS), for their encouragement and strong support of mentoring programs, and to the U.S. DHHS, OWH (contract number: 282980051) for funding us as 1 of the 4 National Centers of Leadership in Academic Medicine, a 3-year project on which our work is based.

REFERENCES