

Office of Staff Wellbeing
Department of Anesthesiology and Pain Medicine
University of Alberta

Mentors' Guide 2014/5

Thank you for agreeing to mentor, or continuing to mentor an anesthesia resident at the University of Alberta.

In this handout you'll find most of what you need to know to be an effective mentor, learn how to keep your mentorship within the rules and will be directed to additional resources that you might need if the going gets tough.

History

Mentorship is a construct handed down to us from ancient times. Greek mythology describes Mentor as a friend of King Odysseus, into whose care the King's son was placed while he went to war. It's probably fair to say that anesthesiology trainees have been *informally* mentored in this and other cities for as long as there have been training programs, but the program that you have undertaken to help with is a *formal* mentorship program.

Ramona Kearney first instituted a mentorship program for new residents in 1994. The idea was that people new to the program and the city would have a resource person for contact every few weeks in the early days of residency. In 2005, Brendan Finucane created a group mentorship system in which residents, one from each year group, were grouped together, mentored each other and selected staff people to facilitate interaction within that group. In 2010, Brent MacNicol created the program that we have today.

I was asked to take over the program this year and moved it from the Residency Program to the new Office of Staff Well Being, which is a distinct entity in the administrative structure of the Zone under the chairmanship of Teresa Eliasson. We did this because we wanted to create a separation between mentorship and training. The goal is for the resident to be completely assured that nothing discussed in mentorship will be used during assessment.

Why do we need mentorship?

Residency is a complex environment. The resident is often far from his/her traditional supports yet has to manage a variety of competing pressures of which learning to become a skilled anesthesiologist is only one. Our program is enriched by the presence of dozens of faculty members but this creates the scenario where individual

resident/staff pairs may only come together on an occasional basis. In addition, during regular interactions in the operating room, the resident is being constantly evaluated, explicitly or not. This places a perceived or real restriction on how easy it is for them to reveal things about themselves that maybe causing difficulty.

Informal mentorship is the *ad hoc* relationship that develops between a staff person and a resident who are of like mind and are drawn together because of personality traits or life experience with specific issues. It's important to understand that the *formal* mentorship program is not intended to supplant this in any way. Indeed, we encourage it. There's no reason why you can't be a formal mentor to one resident and informal mentor to any number of others. If you're doing it, keep doing it! Unfortunately, informal mentorship is not sufficient for everyone. For example, some residents might never find the right person to mentor them informally despite needing such support.

What is formal mentoring?

Formal mentoring is a contracted relationship in which the terms of the relationship are clearly set down and defined. The resident knows that the staff person has been specifically delegated with the task of being their mentor and that there is a clear line of demarcation between their interactions in the mentorship program and those that might take place in the operating room. Because these relationships are formally contracted, there is a clear mechanism for exiting them. In addition there is the opportunity for us to give support and feedback to mentor within this structure.

'Formal' doesn't mean scripted or awkward. A mentor can and should be warm, friendly, caring and compassionate but (s)he is not the mentee's friend. That distinction may be a little subtle but the important thing about friendship is that it is a bidirectional relationship in which each party gains from the other. While there are some side benefits to being a mentor, formal mentorship exists solely for the well-being of the resident.

What do residents need?

In a 2014 survey, I asked our residents what they thought would be the most useful things to talk about in the mentor relationship. The top four were:

- (i) Finding post-residency jobs or fellowship training
- (ii) Exam preparation strategies
- (iii) Work-life balance,
- (iv) Learning the culture of the profession and institution

There are no limits on what may be discussed, but as a mentor it's probably a good idea for you to have some basic knowledge about these areas. You should learn something

about forthcoming job opportunities in your hospital or subspecialty by talking to the site chief or divisional director. Maybe you're well connected with another locale and you could make inquiries about potential jobs coming up. If you're not involved in the Royal College examination process, you might usefully acquire some knowledge about how the exam works, especially if, like me, you took the test many years ago. Incidentally, I also asked the current *mentor* group how comfortable they'd be discussing these issues, and all expressed high (in some cases almost surgical) degrees of confidence. The two areas that mentors felt least comfortable discussing were spousal difficulty and resident mental health, but there are ample expert resources available in these areas.

A significant number of residents want the ability to exit their formal mentor relationship without hurting feelings or creating resentment. This is a big, scary issue for our residents and I take it very seriously. There is simply no point in perpetuating the fiction of a dysfunctional pairing that is not supporting the resident in any way. At the University of California in San Francisco where they have a similar program, 60 to 70% of residents change mentor at the end of the first year when the option is offered. I wouldn't be surprised if several of our residents take advantage of the same opportunity. Many of our existing mentor-mentee pairs have evolved somewhat randomly and in the survey, only about half of our residents were satisfied or very satisfied with their mentor relationship.

What does a good mentor look like?

(i) You have a big heart and a small ego. I hope you've chosen this role because you're interested in playing a part in the development of excellent young clinicians who are well adjusted and happy. In truth, your hope should be that they exceed you in all areas of personal and professional development. Don't undertake or continue the mentorship role just because the idea of someone coming to you for help appeals to your ego. And if you secretly think that seeking help is a sign of weakness than you're probably not in a good position to give good mentorship.

(ii) You see yourself as a role model, at least in some capacity. Some physicians find it difficult to acknowledge this in themselves, feeling that it gets too close to bragging. That's usually unfair: To me, a role model for residents is simply a person who evidently enjoys his or her job, is reasonably good at it, has a good work life balance and enjoys a reputation for these characteristics amongst others. That certainly doesn't mean that you need to be perfect in all areas, nor be some kind of perpetually smiling superhuman. However, if you really don't feel that your own life offers much to emulate, you might want to think seriously about whether mentorship is for you. Incidentally, it's not important what stage of career you're at nor whether you practice a subspecialty nor which site you practice at. The residents have indicated that while each of these

characteristics offer something different, none of these are impediments to good mentor relationships.

(iii) You know how to listen. This is a skill that some people find easier than others. It's not your job to fix every problem that the mentee brings to you. Rather, it is often your job to direct the individual towards finding the solution for him/herself.

(iv) You could deliver an uncomfortable truth kindly if you had to. A good mentor is willing to say things the resident needs to hear that might not come from any other source. If there is something obvious about the resident's personality or performance that going to impede their progress in the specialty than it is best delivered by someone such as a mentor who is known to only have the resident's best interest at heart and is not involved in the evaluation process.

(v) You could handle the resident saying they don't want to be your mentee anymore. Formal mentorship is a contractual relationship, not a personal relationship. When I surveyed the existing mentors in the program I made a point of asking each and every one of them how they would react to such a request and everyone said that if the resident felt that the change in mentor was necessary than that request should be acceded to without further ado. I expect all mentors to honor that commitment and it will be explicit in the membership agreement that you will sign with your mentee.

(vi) Finally, it's important to me that all mentors are willing to adhere to the small number of rules and regulations that are put in place in order to make the program run smoothly.

Rules of the road

(i) Mentors schedule the meetings. It is the **mentor's** job to schedule a meeting with the mentee **every four months at least**. (Note that that that doesn't mean that you have to schedule it four months in advance!) The meetings can be as long or as short as you like but they must be prescheduled. It is the mentor's responsibility to keep a record of the date and time on which these meetings take place and forward it to me. The reason for this rule is twofold: A strong sign of a dying relationship is unwillingness of the parties to interact. If a pairing is not meeting for prolonged periods of time, I need that information so that I can investigate whether or not it is really working. Secondly, by attending pre-scheduled meetings, the resident is not made to feel that they are bothering the staff person unnecessarily. The alternative, which some mentors have adopted in the past, is to simply let the resident contact them when they are having trouble. This is not acceptable because it makes the resident wonder whether or not the problem at hand is important enough to initiate a mentor contact.

(ii) Mentorship meetings must be private. There are few fixed rules about where to

meet, but I must insist that all meetings take place in an environment that is away from other people's hearing. A closed-door office in the hospital is best, but you could go to a restaurant or a coffee shop for example, provided no one can overhear you. The operating room during a case is not an acceptable venue.

The Faculty of Medicine, through its Learner Advocacy and Wellness Office, has a strong stated position against meetings in the mentor's home and on meetings at which alcohol is served. The concern about alcohol is that the resident doesn't really want to drink, but accepts it because they think that they would be offending you if they did not. There is also the potential nightmare scenario of this leading to impaired driving.

You may not meet in the resident's home under any circumstances.

(iii) Mentor meetings are confidential. Take whatever you hear in a mentor meeting to the grave. The exception to this rule is if you obtain information that makes you concerned that the resident or any other person may be in danger. In that specific event, you must do whatever is necessary to mitigate that risk, which may involve divulging something you learned. You are covered by statute if you do that and the residents explicitly consent to that in the mentorship agreement. In addition, the mentorship agreement also explicitly allows you to break confidentiality to consult with me or the Faculty's expert or the AMA if you simply don't know how to proceed in any given situation.

Being a mentor does not remove you from your traditional role as a clinical teacher and evaluator for that individual, but you must not allow information gleaned in the mentor role to be used in daily or summative evaluations. (E.g. 'had a lot of trouble with lines today, seemed pre-occupied': Acceptable. 'Had a lot of trouble with lines because he's still pre-occupied with his relationship issues': Not Acceptable)

What to do during a mentor meeting

Essentially, you should let the resident drive the agenda. However, during the early stage of your relationship, it's important to get to know as much as you can about the resident. I think it's a good idea to ensure that they have a family physician, that they have adequate provision for the basic necessities of life such as housing and transportation, and that they have a healthy inventory of resources when it comes to friends, recreation and leisure. Beyond that, you should focus on listening to the residents concerns and helping to address those where appropriate. Residency passes quickly, and a good mentor ensures that the resident has at least some thoughts about the practicalities of setting themselves up for their early years in practice.

Many residents simply need reassurance that they're doing okay and for the well-adjusted resident your role may never be more than to act as a motivator and supporter.

I keep brief, factual notes about what is said in mentor meetings. It helps me remember what was said before so that I can monitor the progress of problems. You don't have to do this, but if you do, you should make sure that it's OK with the resident. Assume that the resident and his attorney will read everything you write down. Keep these notes securely locked away.

If a resident presents you with a problem, your response to it depends on its urgency and how well equipped you feel to deal with it. The first thing is probably to restate the problem in dispassionate language so that you and the resident both know what you are talking about explicitly. If you can't make a sensible suggestion about what to do then don't worry. There are plenty of resources available to you. Here are three good options:

If the problem is to do with the mentorship program such as a mentor mentee pair that is not working or something similar, or if you're not sure where to start, the best thing to do is to contact me. My contact information appears in the membership agreement, which you will sign.

A great resource is Dr. Erica Dance. She is the Assistant Dean for Resident and Fellow Affairs in the Learner Advocacy & Wellness Office of the Faculty of Medicine & Dentistry. Dr. Dance is a practicing Emergency Medicine physician with considerable experience in resident wellness and she has explicitly made herself available to both mentors and mentees to assist with problems of any kind. She knows the wellness landscape intimately and will certainly be able to direct you to the appropriate resource. Her contact information also appears in the agreement.

Another excellent option is the Physician Family and Support Program of the Alberta Medical Association. All residents have access to the service and it is available on a 24/7 basis. You can certainly call the service on the resident's behalf if desired.

Keeping appropriate boundaries

Whenever two people interact in the context of an asymmetrical power gradient, (and indeed even when there is no such gradient), there is the potential for boundary violations. We all want to do everything we can to ensure that boundaries are maintained.

Mentors are not friends although they should be friendly. The more obvious boundary crossings obvious to everyone and I don't need to go over them in detail here. However, boundary crossings need not be sexual in nature. If you have even the slightest feeling that boundaries are being crossed then there is a strong possibility that they have been and you should seek advice.

Some more subtle signs of boundary crossing might include:

- Feeling that you are overly responsible for the resident's progress and well-being.
- Feeling that you cannot say no to the resident's requests.
- Inappropriately timed or excessively frequent communication. In a genuine emergency you should make yourself available at any time but if contact is taking place on an urgent or out-of-hours basis for manifestly non-urgent issues, then something is amiss.
- Strong concern about the other party's emotional response to what you plan to say. The feeling that you are treading on eggshells when it comes to saying something important is a warning sign and probably indicates that the pairing needs fixing or replacing.

Other developments for 2014

(i) All residents will be matched to a mentor of the same gender. A substantial minority of residents has asked for this. We won't be breaking up any pairings that are currently in place that are working well but happen to be gender discordant, but all new pairings will be gender concordant from now on.

(ii) Each mentor will only formally mentor one resident. In the past, we've tended to overload some mentors and this is not an appropriate use of our rich and diverse faculty base. Again, no existing pairings will be broken up just for this reason but as those residents graduate each mentor will only have one mentee.

(iii) Mentor contracts will now only run for one year but will be renewable. My hope is that the message will get through loud and clear to the residents that it's perfectly okay to ask for a switch at the end of each academic year if they so desire.

(iv) We're going to have a mentor gathering session at which we can swap stories about mentorship and learn from each other as to what works well and what does not.

(v) Dr. Dance has agreed to come and give mentors a talk about resident wellness which will touch on many of the things the residents will bring up and which will be scheduled sometime during the fall, I hope.

(vi) Those holding positions of responsibility in the department or the zone will gradually be removed from the mentorship program. I thought carefully about this, but I feel that Site Chiefs or Divisional Directors who might be responsible for handing out jobs probably should not be mentors in order to avoid creating a perception of a conflict of interest resulting in a bias towards that resident. Again, we won't be breaking up pairs just for this reason. I plan to withdraw myself too and stick to program administration once my two mentees have graduated. We have lots of other people who'd like to be mentors.

Thank you!

Thank you once again for undertaking this role. Please feel free to give feedback or ask questions at any time. All mentors that I've spoken to find the process of nurturing these young physicians to be rewarding and well worth the effort. The program is certainly much appreciated by the residents themselves.

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Mentoring Agreement

This agreement is made between Dr. _____ (mentee)

and

Dr. _____ (mentor).

Description of constituent activities: Mentorship is a formally constituted relationship, in which the mentor undertakes to support and guide the mentee during his/her residency training, with particular emphasis on learning those aspects of becoming an anesthesiologist which are not found in textbooks and are not learned in the clinical environment. These might include things such as learning the specialty's culture, handling stress, acquiring satisfactory work life balance, dealing with loss or conflict, managing feelings after medical mistakes and procuring post residency training and employment. Discussion within the context of this agreement will be referred to as the *mentoring relationship*.

Terms of participation: Entry into the mentoring relationship is entirely voluntary for both parties. Either party may leave the mentoring relationship for any reason. If this is desired, the mentorship program co-ordinator Dr. Saifee Rashiq should be contacted, in confidence, to arrange reassignment (srashiq@ualberta.ca, 780.407.8896, 780.909.6044)

Duration of Agreement: The term of this agreement is for one year from July 1, 2014 until June 30, 2015 but may be renewed annually by mutual agreement thereafter.

Minimum meeting requirement : If this is the first year of this mentor-mentee pairing, the first meeting between the two parties must be arranged by the **mentor** and must take place before August 1 2014. Otherwise, and thereafter, the **mentor** is required to ensure that the mentor and mentee meet face-to-face on a formally scheduled basis at least once every four months. The **mentor** is required to record the dates of these meetings and to forward them to Dr. Rashiq upon request. Any mentoring relationship not meeting this requirement will be automatically reviewed by Dr. Rashiq for possible reassignment.

Confidentiality: Nothing that is disclosed within the mentoring relationship may be used for the academic or professional evaluation of the resident at any time, whether the mentoring relationship is intact or not.

Anything said within the mentoring relationship will be kept confidential by the mentor, with two general exceptions:

(i)The mentor believes, on reasonable grounds, that the disclosure of information obtained within the mentoring relationship will avert or minimize a risk of harm to the health or safety of a minor, or an imminent danger to the health or safety of any person

