**Mentorship and Coaching**

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Introduction

A residency program can assign faculty members to serve as advisors, preceptors, tutors, and/or coaches to residents to help them succeed, or the residency program can have residents select faculty members. These roles include mentors and coaches. Mentorship should also be provided for junior faculty or those new to academic medicine.

A new position or role is a common time to consider mentoring or coaching. Examples include entering residency, transitioning to the senior resident role, and preparing for matching into a subspecialty fellowship or starting an attending position. A resident who is experiencing academic challenges (includes professionalism issues) can benefit from coaching.

There is a difference between coaching & mentoring. 1 A common quote from an unknown source says, “A coach has some great questions for your answers; a mentor has some great answers for your questions.” An analogy with driving a car helps to define the differences between these roles. A mentor will share tips from the experience of driving cars. A coach will encourage and support you in driving the car.

Learning coaching skills and having a coach are both becoming a regular part of a leader’s (PD, APD, faculty) working life today. The challenge most frequently heard from coaches and leaders alike is when to coach, when to offer advice (mentoring), and/or when to be directive (managing). As a residency program leader, you must be able to move smoothly along the continuum between coaching, mentoring and directive management.

Mentorship

Mentorship is a bidirectional process that benefits both the mentee and the mentor. Mentees have increased job satisfaction along with increased productivity and greater opportunities to network and advance their careers. Mentors can advance their career with increased development of leadership skills along with increased motivation and interest resulting in feelings of enhanced personal fulfillment.1 In addition to mentees and mentors, organizations also benefit from mentorship programs. Mentorship programs lead to improved work performance with heightened strategic planning and communication. Mentorship programs are cost effective and result in reduced employee turnover with retention of organizational information and culture.2

Mentors are experts in a skill. Mentees may want mentors in research, clinical skills, professional development, etc. depending on residents’ interests. A mentor should help their mentee achieve the mentee’s professional goals and can sit at any level in the institution’s hierarchy. A mentor provides career advice and psychosocial support for the resident’s personal and professional development while helping the resident understand and navigate institutional politics. Mentors increase residents’ sense of competence and self-worth and understand the practice of pediatrics and what it means to be a pediatrician.

Content areas for mentoring include bioethics, clinical informatics, medical education, research, work-life satisfaction, wellness, quality improvement, patient safety, administration, clinical practice, advocacy, global health, and leadership.

*Characteristics of Good Mentors and Mentees*

Characteristics of a good faculty mentor include acting as a professional role model and demonstrating confidence in the resident’s ability to meet professional goals. The mentor values the resident as an individual and creates a positive and supportive professional environment for the resident. A mentor should be generous with feedback, positive and constructive. The mentor should encourage independent thinking and behavior by the resident. The mentor must be willing to invest ample time in the resident and include the resident within the mentor’s professional circle. The mentor provides opportunities to support the resident’s professional growth and give credit to the resident for the resident’s work on projects.

Programs should educate residents on what mentors expect from their resident mentees and the characteristics of being a good resident mentee. The mentee must be motivated to learn, take the relationship seriously, and take the initiative in establishing the relationship. The mentee should be flexible and understanding of the mentor’s demanding schedule and be prompt for meetings with their mentor. The mentee must show interest in professional growth, be goal-oriented, and accept and act on feedback from their mentor. The mentee should develop academic/professional goals prior to meeting with the mentor.  The mentor should not have to spend excessive time trying to schedule meetings with the resident.

*Mentoring Models*

There are two different mentoring models: traditional and contemporary. In the traditional model of mentorship, a mentor picked the resident and had much in common with the resident. In this model, only residents and junior faculty who are starting their careers need mentoring. Traditionally a mentor tells the resident what their career goals should be and how to reach them. In the contemporary model, residents pick their mentor(s). A program identifies a group of mentors that residents can select from based on the mentor’s previous mentoring success. A mentor may have little in common with the resident and mentoring is for any stage of life and career and is not limited to training. Residents may have many mentors in different areas. The mentor facilitates resident decision-making and problem-solving. Some programs use peer mentoring where resident peers mentor each other individually or in groups. Some residency programs assign a senior resident advisor to an incoming intern so they can help them transition to residency and navigate the challenges of intern year.

Suggestions for successful mentoring programs include orienting residents and mentors to the residency mentoring program. The residency program should send mentors and residents expectations at the beginning of every academic year. The residency program defines when, where, and how often the residents and their mentors meet. The residency program sets standards to report meetings between the residents and their mentors. Consent for information exchange related to these sessions should be obtained from the mentee, the mentor, and the residency program’s leadership team. Clear expectations as to what information will and will not be reported back should be presented to all parties involved prior to the start of the mentoring relationship. The residency program should send evaluations to the residents and mentors about the mentoring program at a minimum semi-annually. The residency program establishes residency program metrics to determine the mentoring program’s strengths and areas for improvement and revises the program accordingly.

Coaching

Coaches are guides who work on improving the performance & wellbeing of the resident through setting goals, exploring values, and creating action plans. Coaches help residents set goals based on the residents’ values. When starting a coaching program, residencies should consider the overall goals of the program. Questions that the program must ask before developing a coaching program include:

* Is this program for all residents or does it focus only on residents who have specific challenges?
* Should the program also provide a coaching program for chief residents, junior and/or senior faculty?
* Is the goal to have a formal coaching program or is the goal to incorporate pieces of coaching in the mentoring program?

The residency program needs buy-in from administration and medical education leadership as coaching programs can be time-intensive and costly. Programs may prefer to have faculty/staff go through coaching training or they can use external agencies to provide the coaching.

Executive coaching is a common type that frequently encompasses a leadership development program with exploring values, completing skills exercises, and obtaining 360° feedback. These programs usually meet weekly to monthly and last for six plus months and may be a good option for chief residents or junior faculty. Resident coaching programs can incorporate components of executive coaching as all residents are leaders in various roles whether that be leading a resuscitation of a patient or acting as the senior resident on a rotation.

Coaching is based out of letting the coached individual guide the session with bringing up topics to discuss. Positive psychology is frequently used in coaching. Coaches should have training in coaching and abide by coaching competencies and ethics. Coaching is not therapy, consulting, or mentorship. Coaches do not tell coached individuals what to do. Instead, coaches use their skills to have the coached individual discover what the best way is to go about achieving their desired results. Success in coaching is achieved not by advising or telling, but largely by questioning to facilitate awareness & self-directed learning. Coaches must have active listening skills. Coaches use motivational interviewing and encourage the development of a growth mindset. The coach does not require any knowledge, skills, or experience of the resident’s field of work. Ignorance can be advantageous and may encourage the coach to ask more neutral and less leading questions.

Residency programs can consider using SMART Goals as a part of their coaching programs. Coaches can help residents develop their ACGME-required Individual Learning Plans (ILPs) as listed in the ACGME Pediatric Residency Program Requirements (section V.A.1.d).(2)).

References

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