What’s a Mentor?
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Are You My Mother? by P.D. Eastman is a favorite children’s
book I would repeatedly read to our children. This is a story of a
baby bird who falls from the nest and then goes on a search for
its mother, approaching all varieties of animals until a kindly
bulldozer lifts it back to its nest, where mother and baby are
reunited. Although there are many iconic themes in this book,
I recall it as emblematic early in my career as I was asking, “Are
you my mentor?”

Mentoring is an essential feature of medical career devel-
opment and one for which there is often a lack of clarity for
both mentee and mentor. As a resident, I was assigned a faculty
member but wondered if they were only someone who signed
papers, reviewed feedback, and documented my progress or
someone I could turn to for advice. As a new faculty member,
I was assigned a mentee and asked myself, “Am I someone who
only documents progress, or provides information, or offers
direction?” The paper last year by Seehusen et al, “Coaching,
Mentoring, and Sponsoring, as Career Development Tools,”
and the paper in this current issue by Al Achkar et al, “How
to Sponsor, Coach, and Mentor: A Qualitative Study with
Family Medicine Department Chairs,” help clarify aspects of
mentorship in family medicine.

Dr Seehusen surveyed family medicine department chairs
about how they had both received and provided career devel-
opment via coaching, mentoring, and sponsorship. While these
193 chairs reported the significant role of mentoring in their
professional development, they had not experienced sponsorship or coaching to the same extent. In this current
issue, we have a follow–up paper. Three of the authors from Dr
Seehusen’s paper join with two additional authors to explore
how coaching, sponsoring, and mentoring were employed by a
purposeful sample of 20 department chairs. In semistructured
interviews, these chairs described their experiences receiving
or providing career development, and the actions charac-
terizing sponsoring, coaching, or mentoring emerged. This
specificity provides a structure for training and clarity for both
those giving and receiving career development. Particular
actions can be assessed for frequency of use and evaluated
for what is effective in what setting and why. Specificity may
also reveal what is missing or unclear. For example, how are
these three components of career development integrated and
complementary? Mentorship is essential, and its goals are
broad and deep. Coaching and sponsoring are more bounded
behaviors and are often time limited. Are coaching and spon-
lorship helpful but not essential?

Only recently have coaching and sponsorship been defined
separately or as a subset of mentorship, giving rise to the
aphorism “A mentor talks with you. A coach talks to
you. A sponsor talks about you” (attribution unknown). The
traditional mentor relationship, usually longitudinal, is char-
acterized as one in which a respected senior clinician invests
in both the professional and personal development of a junior
clinician. It may include not only coaching and sponsoring but
commonly advising, teaching, and role modeling. It may
be deeply personal, or task focused. Formal mentoring is
often assigned by institutional leaders while informal men-
toring is typically initiated by the mentee. Mentors may be
multiple, transient, or lifelong and may become friends. The
descriptors of effective mentors can be daunting, describing
the perfect professional parent.

While variable, mentoring is almost universally recognized
as important. Successful individuals attribute career satisfac-
tion and achievement to their mentorship. Mentorship has
been correlated with faculty retention, scholarly production,
career satisfaction, better developed professional identities,
and balance between professional and personal lives. Mentor-
ing is especially important for those who have been
systematically disenfranchised. The most well–studied
group is women followed by individuals underrepresented in
medicine (URiM). These individuals are not only dispropor-
tionately missing from leadership positions, but they also
have higher attrition rates, lack role models, are stereotyped,
and experience conscious and unconscious bias, harassment,
and frequently lower salaries. These obstacles are magni-
fied with the consideration of intersectionality of race or
ethnicity, sexual orientation, age, or disability. A recent
scoping review focused on mentoring for women found that
mentoring can both uncover inequalities and help mentees negotiate success but also revealed sexual harassment within mentoring relationships and continued difficulties reporting sexual harassment. 

Challenges and failed mentor relationships were characterized by poor communication, lack of commitment by either mentee or mentor, lack of experience, personality differences, competition, conflicts of interest, and at worst, abuse of power by the mentor. Even with a high level of satisfaction, both mentors and mentees call for clear communication of expectations, and possible contracting. 

The lack of clear, consistent definitions of mentoring makes it difficult to direct, evaluate, and establish training programs and improve mentorship. While the specificity elaborated by Al Achkar is helpful, there is little empiric evidence for the value of one type or characteristic of mentoring versus another. Research about who and what makes for good mentorship requires consideration of its content and developmental context. In a systematic review and thematic analysis, Radha Krishna et al conceptualize a mentoring continuum while Coe describes a multidimensional mentoring team. Both models incorporate relationships changing over time to meet the evolving needs of the mentee. Since career growth is dynamic and leadership growth is developmental, successful mentorship is a complex, adaptive process.

Less has been written about the value of mentoring for the mentor, although it is often part of a senior faculty’s job description. Mentorship is not a one-way street. I have had the privilege and pleasure of sponsoring family physician colleagues. It is a great joy. Junior faculty may need to be reminded that they are offering their mentors a valued experience. They become part of one’s legacy. Moreover, reverse mentoring, initially focused on research integrity, presents the potential for two-way skill building and information transfer and may mitigate intergenerational gaps and power imbalances. My coaches now are usually more junior than I in years but have skills that I do not.

What do I tell junior faculty about mentorship? First, it’s a good thing! Second, be clear about what you hope for and need from your mentor and continue to communicate throughout the relationship. Unclear expectations cause disappointment. Finally, have multiple mentors who offer different strengths for your multiple and changing roles and needs. One size does not fit all. Moreover, you will change over time, and the advice, direction, and support you need will also change. When I was a junior faculty member with young children doing full-scope family medicine, the greatest mentors were those who could talk to me about breast feeding while working, managing child care disasters, and how to speak up as the only woman at the table.

Who should be a mentor/coach/sponsor? All of us. One can certainly be a mentee and mentor at the same time. Mentorship in the broadest sense is defined as support for another’s professional development. It is both deeply personal in the moment and adaptive over time. Fortunate among us are those who have been a mentee and a mentor, a coach and a sponsor, or an advisor or role model. We can all aspire to build those trusting relationships that will also, sometimes, lead to lifelong friendships.

I will conclude with what I consider closest to my personal sense of mentorship:

We’re here for a reason. I believe a bit of the reason is to throw little torches out to lead people through the dark.

Whoopi Goldberg

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