Support programs for rural physicians, including mentorship

By Kirstie Overhill MD CCFP FCFP

There is considerable interest in the topic of Mentorship in BC. Mentorship and other social supports for physicians can arise spontaneously, but there are many situations where intentional fostering of social supports can be advantageous for the well being of physicians and as a tool to promote recruitment and retention in rural communities.

Many stakeholders are developing mentorship programs for students and graduate physicians. In this context is important to understand what works most effectively. In order to clarify the discussion, it is helpful to develop and agree upon a common understanding of terms. There is not necessarily one right definition for any of these concepts and in the end the best definitions are those which are most useful, especially from a rural standpoint.

TABLE OF CONTENTS

TYPES OF SUPPORTS FOR RURAL PHYSICIANS

1. Mentorship

"Mentorship is a professional relationship in which one person (the 'Mentor') shares knowledge, information and perspective to enhance the personal and professional growth of someone else (the 'Mentee')."

Mentor functions could include:

- teaching about specific issues
- coaching on a skill
- sharing resources and networks
- providing a safe learning environment; and
- challenging the Mentee to move beyond his/her comfort zone.

Mentoring focuses on the total development of the Mentee, including psychosocial development in the new rural environment, and/or educational needs. Compatibility forms the basis for the Mentor/Mentee relationship, although the agenda of the relationship is focused on the needs of the Mentee.

Mentoring is not Supervision, and takes place outside of a manager relationship. Mentors do not evaluate or provide performance reviews, nor do they provide preceptor evaluations of educational performance.

Informal Mentorship

Mentoring can be informal, based on self-selected 'chemistry' of the individuals involved. This frequently occurs on a spontaneous basis and provides a sense of fulfillment to both Mentor and Mentee. It is possible to encourage informal Mentorship relationships by increasing opportunities for interpersonal engagement within communities or within organizations.
In general there is no training or support for the Mentor in informal mentorship, and there are no goals established or measured outcome. There can be overlap with other forms of physician support, in particular with peer support.

Formal Mentorship

Formal Mentorship programs aim to match a particular Mentee with a compatible Mentor. Goals are established from the beginning and outcomes are measured. Training and support to the Mentor are supplied. Formal mentorship can be funded or unfunded. Considerations for formal rural mentoring should include;

> ***a. Establishing Mentor-Mentee relationships that are "closer to home."*** Face-to-face interactions are ideal. There are however limitations including number of trained or willing mentor physicians available in a small community. Options could therefore include relationships within a community, within the same region or within similar communities, mediated by teleconferencing where available. When there is a preference on the part of the Mentee for mentorship (gender, cultural background), a choice should be available if possible, as it is important for the Mentor to have personal credibility for the Mentee.

b. Boundary Issues should be considered since separation of roles can be difficult in rural areas. The Mentor should not be a Supervisor or the personal physician of a Mentee, due to role confusion and the likelihood of boundary violations. Where roles (including social) are overlapping, a discussion of boundaries should be encouraged to avoid misunderstanding.

c. Confidentiality is particularly important in the context of rural areas, and is necessary to develop trust in the Mentor-Mentee relationship. There should be discussion and mutual agreement before sharing of information occurs.

d. Evaluation of Formal Mentorship could be completed via confidential participant surveys. Mentor reporting should not include assessment of the Mentee's professional abilities or functioning, to preserve confidentiality in the relationship.

Additional evaluation assessing the impact of mentorship programs on recruitment and retention outcomes could prove to be valuable and is worth discussing further.

e. Duration of Mentorship should be discussed. Ultimately most Mentorship relationships evolve, as a new physician grows more confident in practice. Many current programs have a defined time frame and are not indefinite – there is a place for official separation.

There may be need for different Mentors at different times for an individual, depending on the primary challenges faced at a given time. Conflict or a poorly functioning mentorship relationship may occur, in which case either participant should be entitled to end the association without jeopardy.

f. Training of Mentors should occur on an ongoing basis and could include formal initial training and ongoing support for if and/or when problems arise.

Mentors should be aware of resources such as the Physicians Health Program, educational opportunities, etc. so that they can direct their Mentee to appropriate programs as needed.

g. Coordination of Mentorship Programs with other resources that support Recruitment and Retention of rural physicians, and with the Divisions of Family Practice, should be encouraged.

h. Consideration of the needs of specialists as well as Family Physicians should be considered. Inclusion of other practitioners such as NPs should be discussed.

2. Peer support

Peer Support occurs when individuals who are colleagues or equals provide knowledge, experience, or emotional, social and practical help to each other, by virtue of relevant, similar experience. There may be an aspect of training of specific skills, and sharing of knowledge and resources.

Peer support often develops informally, but formal arrangements may be considered as well to answer specific needs. It offers the potential for long-term ongoing supportive relationships between physicians, either in the same community of via remote connection.

3. Coaching

Coaching is a teaching, training, or development process wherein an individual (the client) is supported while achieving a specific personal or professional result or goal. This may involve accelerated learning, developing peak performance, fine-tuning a skill, solving a problem or learning new behavior(s). More specific terms, such as "Clinical Coaching," can help clarify whether the coaching is intended to increasing a clinical skill.

Although there can be overlap in definitions of mentorship and coaching, it may be useful to refer to coaching as a process that is more goal-oriented, and less focused on psychosocial development than that of mentorship. There may be less emphasis on a long-term ongoing relationship between the individuals.

In other contexts, the term coaching is used to describe a counseling relationship (e.g. "Life Coach") where the client is aided with career or life decisions and skills in a non-directive manner by a professional coach. In British Columbia, coaching is available in association with the Leadership Institute of the CMA and in association with the Physician Health Program.

4. Leadership

Leadership is a process of social influence in which one person (the leader) can enlist the aid and support of others in the accomplishment of a common task. There are many different models of leadership and educational programs involved with teaching a variety of leadership skills. Leadership has, for example, been described as similar to coaching but relating to a group rather than an individual.

Leadership positions in rural communities are seldom sought after opportunities. Rural physicians for a variety of reasons – including desire for independence and heavy clinical workloads – often view local administrative positions (e.g. chief of staff) as an unpleasant necessity. Despite this, rural physicians will often spontaneously involve themselves in clinical leadership initiatives that are directly tied to improved patient care. Involvement in provincial or national organizations involves considerable travel time to meetings, although the increase use of teleconferencing and videoconferencing has helped mitigate time demands on rural leaders.

A physician leader must be seen as a competent clinician in order to have influence over their peers. Leadership training geared to the needs of rural physicians would be useful. General leadership training for physicians is available through the CMA.

5. Counseling

The term Counseling can be used in a variety of contexts, from career counseling to counseling for a physician with personal issues. Because there are pre-existing definitions and uses of the term counseling, it is necessary to describe the intended context and use of the term counseling (e.g., career counseling, clinical skills counselor) before engaging in a discussion.

6. Role modeling

A Role Model is a person who serves as an example – particularly in behavioral or social ways – for other people to emulate.

Informal events involving social activities and contact between medical students and rural physicians, offer the opportunity to create positive role models for the students. The undergraduate rural rotations, although primarily an educational experience, also provide opportunity to positively role model not just rural physicians, but rural communities and rural health care.

7. Educational programs

The range of educational opportunities designed to meet the needs of rural physicians includes but is not limited to: conferences, distance education, traveling roadshows, clinical training opportunities (REAP), and journals and online resources. Many of the strongest educational programs include aspects of role modeling, peer support, coaching and mentorship to support the transmission of knowledge and/or skills. The preceptors involved in these training programs may have a mentorship role, but their primary focus is educational.

DISCUSSION OF FUNDED/ UNFUNDED PHYSICIAN SUPPORT INITIATIVES

It is useful to consider rural physician support programs from the perspective of funded or unfunded initiatives.

1. Mentorship – Informal and Formal

Typically, informal mentorship is not a paid relationship. It may, however, be valuable to financially support the facilitation and promotion of informal mentorship though the development of informal mentor training or support of organizations offering mentorship opportunities.

Formal mentorship involving specific deliverables from the Mentor may require financial compensation, depending on the time commitment involved and expectations of the program. The Mentee would generally not be compensated for a program which is to their benefit, but other advantages such as CME credits can be offered. Certainly support for any expenses incurred by the Mentor should be acceptable, such as travel costs for in-person meetings with the Mentee, training, teleconferencing support, etc.

Although mentorship offers great value to all program participants, it has the potential to negatively impact an individual's medical practice. Potential mentors who operate on a fee-for-service basis may faced a drop in income or a decrease in personal time that reflects the time spent with their Mentee. Mentors compensated via contract would likewise not be compensated for this activity as contract physicians often work significantly more hours than is required per their agreements – they will unlikely be able to fit a Mentor role within their designated hours. Mentoring activity would fall into the category of "non patient care" which is financially uncompensated time. A consideration of the different financial models of rural health delivery should be discussed when designing a mentorship program.

2. Peer support

Peer support is generally unfunded for networking physicians and/or students. A peer support program as a whole could be supported financially to provide, at a minimum, administrative funds and compensation for leaders participating in the process. Rural peer support programs could also be supported through provision of technology to facilitate remote contact between communities and practitioners. It is interesting to note that regular meetings with colleagues are supported and compensated for Nurse Practitioners in British Columbia.

3. Coaching

The role of Clinical Coach could be funded or unfunded depending on the time commitment and method of remuneration for the physician coach. Apart from the benefit to the physicians of increased skills, coaching may benefit the organization/Health Authority in terms of improved care, reduced rate of transfer from a rural facility to a referral centre, etc. Coaches associated with the Physician Health Program (may be physicians or non-physician, are chosen by the client,) and typically charge their clients at a rate of $250.00 per hour. There is no current proposal that this be funded except by the individual clients seeking coaching.

4. Leadership Programs

Leadership training can be funded or unfunded depending on the program. A common source of Leadership Training is the PMI (Physicians Management Initiative) associated with the CMA, which occasionally provides financial support in some cases. There is not presently a specific module for training rural physician leaders.

5. Education Programs

Rural physicians increasingly receive funding to participate in educational programs. Funding is available through programs such as REAP, or through the Rural CME funds available to physicians providing service in RSA communities.

FUTURE DIRECTIONS/SUMMARY

At present there are a number of programs underway in British Columbia designed to mentor and support a range of participants, including high school students, medical students (including First Nations undergraduates), new graduates and IMGs, and Mothers in Medicine. RCC*bc* is undertaking research to establish best practices in different categories of physician support, and collaborating with mentorship program providers. Through good communication RCCbc hopes to share information about successful initiatives, and seeks to promote and encourage a culture of social support among rural physicians.