MENTORING

Floyd D. Loop, MD

Mentoring may be experienced at any time in life, but the universal time to encounter role models is during formal education, when we are most impressionable. Mentoring is only 1 variable in the acquisition of experience. Our habits and conduct during school and postgraduate studies and often the characteristics that we develop are, in part, molded by those we emulate, consciously or unconsciously. So a mentor is an exemplar whose characteristics the protégé may seek to emulate.[1]

To be a mentor is an opportunity that is open to nearly everyone. You are a mentor any time you are a manager or a faculty member or are just orienting a new employee to the workplace. Mentors are guides. They lead us along the journey of our lives. We trust them. They have been there before; they have the experience that we hope to acquire. They embody our hopes, light the path ahead, interpret signs that warn us of dangers, and, if they are good mentors, point out unexpected opportunities.[2]

The term *mentoring* comes from the ancient Greeks. The word evolved from Homer's *Odyssey*. Mentor was the trusted friend of Odysseus. While Odysseus was away fighting in the Trojan war, his son, Telemachus, who had been placed in the charge of Mentor, matured into a fine young man. Women will point out that when Zeus' daughter, Pallas Athena, wished to help Telemachus, she assumed the guise of Mentor and, of course, as a woman, was even more competent and effective a teacher than Mentor himself.

Here are some practical aspects of mentoring. Our professional lives generally fall into 3 phases: education, achievement, and payback, the last phase of which is the most typical time to mentor. Generally, mentoring requires maturity, self-confidence, and willingness to commit time and energy beyond that required for teaching.[3] The mentor is usually considerably older than the protégé and is someone who has acquired much experience and seniority; someone who is more than a didactic teacher or a colleague; someone who is a sponsor, an advisor, and a model; someone who has the time to counsel and support; someone who can communicate direction; and, as I mentioned earlier, someone whose high standards of excellence the protégé can emulate.[4]

The hallmarks of a master mentor are well known: collegiality and knowledge; a reputation for common sense, competence, responsibility, and good judgment; and the security that enables one to share credit. Students look for compassion, enthusiasm, and proficiency and the ability to explain difficult subjects.[5] Dan Tosteson, a former Harvard Medical School dean looked at it this way: "We must acknowledge again that the most important, indeed, the only thing we have to offer our students is ourselves. Everything else they can read in a book…." [6]

Our training programs depend on the scholarly activities of teaching, conducting research and evaluating its validity, learning intellectual inquiry, preserving and disseminating information, monitoring and mentoring, and demonstrating the value of progress through innovation. Academia comprises the 4 scholarships of discovery, integration, application, and teaching. The chief responsibility of an academic institution is to educate competent, caring physicians, to foster the habits of life-long learning and professional renewal, and to provide an environment of inquiry and scholarship.

Educators have been responsible for building in you, the next generation, the character and skill to practice surgery; but mentorship, as many of you have experienced, is often the catalyst that launches a productive career.

Mentoring is not limited to the academic setting; you can influence younger persons positively wherever you are. A mentor's role is to provide the insight necessary to better cope, to better serve, to survive and prosper, and to contribute to humanity, in our case, through a very long career in a great profession. The process of mentoring tends to be informal (discussion on rounds, during private visits, while socializing, and during relaxing moments after or even during surgery).

Mentoring is crucial for the development of the highest personal standards, the most fundamental of which is knowledge. Somehow it has to be instilled into students that the pursuit of knowledge must be sustained

From The Cleveland Clinic Foundation, Cleveland, Ohio.

Address for reprints: Floyd D. Loop, MD, The Cleveland Clinic Foundation 9500 Euclid Ave, Cleveland, OH 44195 (e-mail: vaughnkl@ccf.org).

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throughout one's life. In surgery, we are deluged by advancing technology and the exponential growth of information. The present store of knowledge has a half-life of about 3 to 5 years, and it is getting shorter all the time. The problem is not that we forget what we have learned; instead, it is the struggle to acquire new knowledge. New knowledge is the true wealth and is much more important than material assets. It does not mean that you should aspire to be poor, but to keep your priorities in perspective.

Physicians, especially surgeons, have an immature, unbridled desire for unmanaged freedom. That is a good quality. However, we also have to keep our interest level up throughout a long and arduous career, and that requires discipline. Boredom often is due to a loss of incentive for scholarship and to worrying about material things. The mentor who lives and breathes medicine can show the younger colleague that it is possible to sustain intellectual drive. Uninspired surgeons excuse themselves from continuing scholarship on grounds that they are not teachers.[7] But they overlook a greater responsibility apart from self-education, and that is educating the patient. C.H. Mayo wrote that the patient is safest in the hands of a person engaged in teaching medicine. To teach, the doctor must always be a student.[8] Sir William Osler was "astonished with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it."[9]

Scholarship goes 2 ways. There are expectations for both the student and the teacher. For any protégé to absorb even a grain of wisdom from a mentor, there has to be mutual respect. There has to be a reciprocal admiration, an esteem that flows in both directions. That respect usually comes from recognition of leadership, which is 1 characteristic that should be passed along in the process of mentoring.[10] There are 4 reasons why leadership is critical to medicine today: Physicians are assuming a larger role in the politics and policies of heath care. Quality assurance demands leadership from physicians. Leadership is important to assure that medicine does not devolve into a commodity that stifles innovation. Finally, leadership is crucial in medicine for innovation and the translation of knowledge into clinical application. You really cannot teach leadership; it is like experience, but leadership is inspired by common sense and by example. The Indiana University basketball coach, Bobby Knight, said "Popular people don't make particularly good leaders. Decisive people with judgment, who aren't afraid to tell other people who don't have such good judgment that their judgment isn't very good, make good leaders."

Too tough, you say. Not at all. Across all specialties is an inability or lack of incentive to stand up for principles. To me, this lack of courage is part of a decline of professionalism. We cannot teach courage or even instill it, but to exemplify courage is the duty of the role model. In this era of changing markets and health policies, our specialty has to stand up for its principles. The business of medicine is threatened, and none of us can afford to be unidimensional. We have to be aware of the trends in medicine and act to prevent the nationalization of a private enterprise. Mentoring does not consist of railing about your political beliefs, which should be kept personal. The point is that, regardless of the way we vote, individually we should endeavor to protect science and education. The next generation has that responsibility. Investment in science is the single best bargain in the United States today because it serves mankind like no other endeavor. Every medical advance comes from science. The United States has the best medicine in the world because of (1) basic science, (2) our postgraduate education, and (3) our pluralistic health care system.

Unfortunately, role models may produce negative as well as positive results. One of the worst forms of negative mentoring is when mentors use their position to gain recognition for their own projects at the expense of the protégé's achievements. This form of insecurity teaches the wrong values, and generally the protégé loses respect. Most of the time, however, negative mentoring reflects a lack of interest or that someone is too busy or that a faculty member does not sufficiently value academic development. This may occur because the faculty member is of junior status and is focusing on his or her own career exclusively, or in the worst case, the potential mentor has a personality that blames everyone else for bad results or is uncomfortable with a protégé of the opposite gender. Again, the point is that mentors are typically older than their pupils, have acquired greater experience, have a larger perspective on life, and are able to articulate values, attitudes, and behaviors associated with professionalism, humanism, and ethical practice. To be a real mentor is part of being an educator.

In our field, the objectives of mentoring are as far reaching as the principles of clinical surgery. First and foremost, mentoring involves setting an example in demonstrating the characteristics of a good doctor, and a good human being, and teaching absolute honesty. An effective mentor draws out what the younger person really wants to accomplish in life. Mentoring may produce a clear realization that will serve as a guidepost in the future. Careers may be shaped by the decisions that we have made on the advice of mentors.

The attachment between mentor and protégé is sometimes not recognized until later in the protégé's career. One experience or 1 encounter that is not appreciated until years later may be a defining moment in a young career. In my case, my entire professional life was changed by the advice of 1 person. During my training in the 1960s, I spent 2 years in the Air Force and performed a large volume of general surgery, enough to gain credit for 1 year of surgical training. But I was still unsure of what I wanted to do after general surgery.

I sought the advice of Brian Blades, professor at George Washington University. Blades was the prototypical thoracic surgeon. He was a pioneer surgeon; he performed the first right upper lobectomy and looked like he came from central casting. He was a great role model, and many young people were favorably influenced by his presence. He had an aura about him that is hard to define, but you knew he was in charge. I had rotated through his service previously. Years earlier, as a first-year resident, the thoracic surgery fellow and I had assisted on a pulmonary lobectomy, and afterward the patient bled and had to undergo reoperation. Blades returned at night to the hospital for this unusual event. The thoracic surgery resident was convinced his career had ended. After the case was finished, Blades summoned us to his office. "This is the end," we thought. Instead, Blades said, "It's late. Would you boys like some dinner?" With that, he took us out for a big meal and told us some stories about an earlier era of thoracic surgery. My esteem and attachment for him, of course, increased considerably after that evening.

When I went to see Brian Blades about a thoracic surgery residency, I had plans of my own about where to go and what to do, and he listened patiently. Then he pointed out another option. He told me that a new field of cardiac surgery was starting, 1 that related to coronary arteries, a whole new era of surgical endeavor, and it was just beginning. He suggested that I go to the Cleveland Clinic to train and then return to the university. To this day, I do not know how he could have anticipated coronary artery surgery because, at that point, the Vineberg implant was the only operation. But, I followed his advice and, looking back, it was probably **the** defining moment. That conversation with the professor was more than mentoring; it shows the wisdom of an older, experienced person who had a genuine regard for a young pupil; there were many others, like me, whom he also helped.

Today, surgery is certainly safer than it was when our forefathers entered this field. But a surgeon's life is more complex. "The future ain't what it used to be." Every physician is now responsible for cost and quality and life-long learning. In the real world of community health care, there is cosmic pessimism about the future of medicine. The outlook for reimbursement is bleak, and the prospect is great for more regulations, competition, and litigation. But you, as a mentor, must show the new generation that for every problem there is an opportunity. Every young physician has an opportunity, an opportunity to do better or worse. You have to show them that life is full of choices. You have to keep reminding residents-in-training that the best surgeons never forget their mistakes, and one has to get better every year despite the morass of politics and changes in health policy. And, do not forget, critical self-assessment is more important than competition. The best kind of competition is to compete with yourself, compete to get better each year. Patients still come to us 1-by-1, not as a set of outcomes data. Medicine is not only an important challenge, but it is also a continuous challenge. Medicine is a great privilege, and the real privilege is in taking care of the patient. Although we cannot teach experience, we can teach perseverance and the importance of scholarship, ingenuity, and enterprise. You know what perseverance is; perseverance is the hard work you do after you get tired of doing the hard work you already did. That, you can teach.

Surgery is much less a free-market model today, where previously incentives were for more and not less. An established group practice, especially 1 related to an academic department, can provide clinical surgery support and relative freedom. A group of doctors integrated with the hospital and with research and education is a model that provides teaching and research opportunities and a reduction in the typical hassle of community practice. You already know this. The practice opportunity chosen may be the most important factor in a career. Too often, the person finishing residency is focused only on income, which is far less important in the short term. For long-term incentives, the young person has to be near the thoracic surgery frontier,[11] where the quickening pace of discovery in science, technology, and clinical practice make this great surgical enterprise more intellectually stimulating and satisfying. Otherwise, life will be dreary.

As physicians, we are privileged to share the most profound moments of people's lives. People facing death, young or old, do not think about what accolades they have earned or what social functions they have attended, what positions they have held, or even how much wealth they have accumulated. At the end, what is on their minds is who they loved and who loved them, who respected them, their family and friends; that circle is everything and is a good measure of one's

The Journal of Thoracic and
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April 2000

life and of whether or not one made a difference. John Steinbeck wrote, “There is no other story. A man, after he has brushed off all the dust and chips of his life, will have left only the hard, clean question: Was it good or was it evil? Have I done it well - or ill?”[12]

Mentoring is part of that story; whether you have made a difference, whether you had the courage to lead your life the right way, the risks you took, the values you had, and the people you helped along the way.[13]

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