The role of the mentor in paramedical education

 The Role Of The Mentor Introduction Mentor, mentoring and mentorship are terms that have received increasing attention in health related circles over the last thirty years. In the ten years between 1978 and 1988 the number of references in the ‘ ERIC’ database, which included ‘ mentor’ as a keyword, increased from 10 to 95, Jacobi (1991). The literature of the following twenty years has continued this growth at a phenomenal rate, and to date there are over 2850 entries. The term ‘ mentor’ is however not a recent phenomenon, and has its roots in Greek mythology.

Legend has it that Homer entrusted the guidance and teaching of his son, Telemachus, to his closest friend ‘ Mentor’, Fields (1991). In more recent times, the eminent French writer Francois Fenelon used a man named ‘ Mentor’ as the lead character in his book “ Les Aventures de Telemaque”, which was published in 1699, Roberts (1999). Following the publication of Fenelon’s ‘ Les Aventures de Telemaque’, the term ‘ mentor’ took the meaning of an older, wiser and more experienced person who takes the responsibility for a younger, more inexperienced persons learning and development, Andrews (1999). Historically, the Ambulance Service has had little affiliation with Higher Education, and as such there has been little motivation to develop staff to become ‘ mentors’. Training and competency assessments were generally carried out by Institute of Health Care Development (IHCD) accredited Instructors, and trainee’s learnt their ‘ trade’ in a vocational setting, under the guidance of State Registered Paramedics. This model has previously been described as an ‘ apprenticeship’, and has

been the recipient of much criticism, due to it’s limitations in the preparation of practitioners, Kilcullen (2007).

Ambulance services across the country are increasingly aware of the need to evaluate their educational provision (Cooper 2005), and of the importance of involving higher education institutes in the preparation of Paramedics, British Paramedic Association (2006). To facilitate the learning of Student Paramedics in practice the authors Trust is developing a cohort of experienced practitioners, referred to as mentors’. This assignment looks at the scope of mentoring, and draws on published literature to define the roles of the mentor in clinical practice. The paucity of research surrounding clinical Paramedic mentoring means that most literature used is sourced from publications primarily aimed at the nursing profession. However logic dictates that in the same way as nursing has long used theories from other disciplines (DeLaune and Ladner, 2002), paramedicine can draw upon research produced by the nursing profession. Defining Mentorship Almost every publication on mentoring begins with a review of the literature demonstrating there is little consensus on the meaning or characteristics of the term, Yonge et al, (2007).

The eclectic mix of processes which all seem to occur under the broad umbrella term of ‘ mentoring’ creates problems in defining exactly what the role entails. The general literature on mentoring is vast, and there are many definitions from which to draw, Madison et al, (1994). For the purpose of this assignment, deliberating the actual definition of the term ‘ mentor’ is probably more a matter of semantics. Contrary to Oliver and Aggleton (2002, p32), who state that “ defining [mentorship] would appear to be of

paramount importance…” this assignment will simply subscribe to the hypothesis that … the mentoring role is defined according to the individual understanding, and is not necessarily based on any of the original concepts of the term. ” Bidwell and Brasler (1989, p23). The authors Trust has chosen a small group of practitioners to fulfil a role, which in essence has the broad function of preparing student Paramedics for post registration clinical paramedic practice.

For this reason, a broad definition of mentoring being a process which is designed to bridge the gap between educational processes and real world experiences (Barker 2006) will be used. Classical Mentoring The classic model of mentoring suggest that mentors should create a safe environment for the protege to be able to expose his or her vulnerability, (Barker 2006). A good mentor demonstrates empathy and understanding, and works to foster relationships conducive to learning. They take time to get to know their student (Bennet 2003), and agree achievable, mutually acceptable learning outcomes early in the placement. It has been reported that the key to effective mentorship is strongly associated with the relationship formed between the mentor and the mentee.

The mentor should develop a relationship built on mutual trust and respect. May et al (1982) suggest that the relationship should be intense, personal and emotional. In reality, seeking these qualities in a professional relationship may appear contrived, and lead to uncomfortable situations. Hunt and Michael (1983) support this, and suggest that mentoring relationships should be a more formal alliance. The mentor role therefore is principally one of support, (Darling 1984; NMC 2004).

It has been suggested that this support can take various guises, and be at many levels. Neary (1997) defines the three aspects of support as educational, managerial, and psychological. Educational Support It seems relatively obvious that the mentor should be clinically experienced, up to date with current practice, and able to share knowledge through experiences and critical enquiry, Morton-Cooper and Palmer (2000). The mentor should be able to identify and disseminate research findings, and keen to ensure that practice is evidence based and current, Kilcullen (2007). It is prudent to remember that simply being with a qualified practitioner does not guarantee learning will take place (Andrews and Wallace, 1999). The mentor should work with the mentee to identify mutually acceptable learning objectives, support the mentee in achieving these, and be prepared to give constructive feedback along the way, Barker (2006).

Several studies have demonstrated that mentors often do not give sufficient feedback (Jowett et al 1994), even though it is considered by students to be one of the mentors key roles, Phillips et al (1996). The mentor should see themselves as a teacher, (Levinson et al 1978), and be comfortable developing the students understanding of the intricacies of their field. The mentor should see it as their duty to inspire students to learn and develop. Poor mentors are often described as uninterested in their profession, and the development of those in the field, distant, unfriendly, unapproachable and intimidating to students, Gray and Smith (2000). The mentor should be flexible in their approach to the education of the student.

There is little doubt that the needs of both the mentor and mentee change over time, as both become increasingly experienced in their individual roles,

and consequently the relationship changes, Maynard and Furlong (1995). The mentor should appreciate this development, and attempt to match their approach to educational needs of the student to their current level of cognitive development. They should facilitate learning and skill acquisition (Elzubeir and Sherman 1995), and consider themselves as a vocational based ‘ trainer’, Earnshaw (1995). Managerial (Clinical) Support The mentor plays a key role in supervising the practice of the student.

A fine balance should be sought between facilitating student exposure to new practices and procedures, whilst ensuring the protection of patients and the public is paramount at all times, HPC (2004). The mentor should take responsibility for supporting and guiding the mentee in all patient management decisions. Psychological Support The mentor should see their role as that of a councillor to mentee’s, (Watson 1999) hence empathy and understanding are considered essential characteristics, Earnshaw (1995). It should be remembered that clinical events which an experienced practitioner considers to be ‘ routine’, may well be distressing or painful for students. A personal reflection of the author involves watching a resuscitation attempt on a young child for the first time, and feeling extremely unsupported and upset.

This insight will hopefully act as a constant reminder of the anguish which can be felt following unsupported clinical practice. Students should see their mentor as an appropriate source of advice and guidance, (Gray and Smith 2000; Barker 2006) to help facilitate professional socialisation. An approachable mentor can allay many of the apprehensions, which face students entering a new and unfamiliar field. Students on clinical placement

with the authors Trust are often young, and experiencing their first extended periods away form home. In the authors experience, many of their anxieties have links to the upheaval which going to university creates.

For this reason a mentor should be prepared to befriend the mentee, and build a relationship which will enable open, honest dialogue between them both. This may take time (Bennett 2003) and for this reason, the mentor should expect that they should be prepared to subscribe time and energy into the relationship, Darling (1984), cited by Andrews and Wallis (1998, p204). In essence, the student or mentee should feel that the mentor is committed to them, and to their learning and development. Finally the mentor should be a positive role model for the mentee. Many skills, techniques, behaviours and acceptable norms are learned through a competent role model, Jackson and Mannix (2001) Positive role model behaviour could include demonstrating competence in skills, maintaining a sense of humour, staying flexible, exhibiting confidence, promoting a positive environment, and showing respect for others, Girard (2006). All traits that we would like to nurture and develop in a student.

The important thing to remember is that students will learn from our examples, whether or not we present ourselves as role models. The wise mentor can use this to their advantage… “ Teaching is not designed to foster role inculcation, but preceptorships and mentorships can achieve this. That is why people say roles are not taught, but caught…” Barnum (1997) cited by Girard (2006, p14) Modern Mentoring – Mentors as Assessors Much debate has taken place over the years in health related journals as to the suitability of mentors as assessors. Northcott (2000) questions whether a

mentor acting as an assessor of performance could influence the mentor relationship, and Boydell (1994) raises concerns that the supportive, nurturing role of mentoring may be jeopardised by the responsibilities of mentor assessment. Theoretically, a mentor should be ideally placed to offer an informed opinion about the competency of the candidate, as they will almost certainly have worked with them for some time, and observed a broader picture of the candidates scope of practice, rather than a brief snapshot. If feedback has been appropriately offered and accepted during the relationship, then many deficiencies should theoretically have been addressed already.

However, questions have been raised over the objectivity, reliability, and validity of mentors acting as assessors, Chambers (1998). Neary (2000) accurately reports that assessments in clinical practice are inherently subjective. This leads to the strong potential for user bias. If the mentor has been successful at fostering a close relationship with the mentee, then failing or referring them will be an extremely unlikely outcome. Further, in the authors opinion, many mentors do not have the experience in assessing candidates to competently assess the students aptitude for the role. Nor do some have the personal strength required to fail students, an opinion mirrored by Pellat (2006), who reports that mentors have identified failing a student as a difficult thing to do.

Ultimately though, this is a somewhat mute point in the current climate of the authors Trust. . There is a notable lack of clinical educators, and those that do exist are preoccupied dealing with vocational assessments of ‘ internal’ candidates. Hence, assessment of University students inevitably

falls as a responsibility of the mentor. Wilson Barnett et al (1995) concur that in many practice settings, mentors do act as assessors.

Until this situation can be addressed, it is important for the mentor to ensure that his justifications for passing or failing candidates are robust, transparent and based on evidence, rather than subjective opinion. This requires the mentor to be honest, self aware and introspective. Conclusion This assignment has looked at the roles, responsibilities and characteristics of a Paramedic mentor. The lack of published literature focused solely on paramedic research has meant that much of the evidence has been taken from allied healthcare settings, of which nursing the most commonly used.

Several conclusions can be drawn from the literature regarding mentorship as a tool in education, and specifically in student paramedic development: 1) Student placement experiences are one of the most important aspects of their preparation for registration (Pellatt 2006), and the mentor plays a key role in this preparation.) The role of the mentor in paramedic education has not been thoroughly investigated. There is a lack of conclusive evidence to demonstrate the roles and responsibilities that a paramedic mentor should fulfil, and how these impact on student education and development. 3) In practice, mentors appear to adopt a generic role (Andrews and Wallis, 1999; Watson 1999), which incorporates the ‘ classical’ aspects of mentorship (Inspirer, Investor and supporter, Darling 1984)), as well as the more challenging aspects of clinical development, (educating, assessment, and clinical supervision).) The role of the mentor is defined according to the requirements of the student, the trust, and the academic institution to which

the mentee belongs, rather than any predetermined concepts of the role. References Andrews M and Wallis M (1999).

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International Journal of Nursing Education Scholarship. Vol 4, Iss 1, Article 19.