Mentoring as a retention strategy to sustain the rural and remote health workforce

Lisa Bourke, PhD, Catherine Waite, MPhil and Julian Wright, MD, FRCP(UK) FAcadMEd

Rural Health Academic Centre, University of Melbourne, Shepparton, Victoria, Australia

Abstract

Objective: To propose a model of mentoring suitable for rural and remote health professionals.

Design: Given the rural and remote health workforce shortage, mentoring is proposed as a workforce retention strategy. Mentoring literature was reviewed; aspects of mentoring highlighted in the literature were considered to ascertain their suitability for rural and remote health professionals.

Method: A total of 39 mentoring papers were reviewed to outline key factors in mentoring rural and remote health professionals. Using this literature, key ways that rural and remote practice enhance or are barriers to mentoring were identified. From this, a model for mentoring rural and remote health practitioners, students and academics was developed.

Results: Four models of mentoring were identified: the cloning, nurturing, friendship and apprenticeship models. The apprenticeship model was identified as suitable for students, the nurturing model as suited to new health professionals to rural and remote settings and the friendship model for senior practitioners/academics. Factors more likely to enable mentoring in rural and remote settings were identified as feelings of obligation by senior practitioners, strong relationships between staff, blurred work/social boundaries, lack of hierarchy, inter-professional practice and technology. The barriers identified included workloads, access to mentors, fee-for-service system for some practitioners, conflicts which could jeopardise working and business relationships, and feelings of being judged.

Conclusions: A model of mentoring for rural and remote health professionals was presented. Given the potential to strengthen and increase the rural and remote health workforce, trialling such a model is worthwhile and evaluation would identify its impact.

KEY WORDS: mentoring, mentoring in rural settings, remote health professional, rural health professional, workforce retention.

Rural health workforce issues

There is a lack of health professionals throughout regional, rural and remote Australia.\textsuperscript{1–3} Statistics vary across regions but suggest the proportion of medical specialists, general practitioners, dentists and physiotherapists working in non-metropolitan areas (23–27\%) is lower than the proportion of the population living outside metropolitan centres (34\%).\textsuperscript{3} Rates are more disproportionate in remote areas.\textsuperscript{1,3}

Literature has also found that most rural health professionals work in regional or rural areas for reasons of lifestyle and location, family (safe place to raise children), financial incentives and values about the best use of their practice. Further, many leave because of management issues, workload, on-call rosters and family issues including opportunities for spouse’s employment and children’s education.\textsuperscript{2,4,5} Retention of rural health professionals is more likely in an environment that is supportive and collegial, where workloads are manageable but where challenging and complex practice remains.\textsuperscript{4}

While the recruitment of the rural health workforce has focused on remuneration, access to professional development and workloads, there has been less attention to increasing personal and professional support of individual rural and remote health practitioners. The goal of this paper is to propose a formal mentoring model specifically for rural and remote health professionals as a strategy to increase retention. Mentoring could support health professionals adjust to rural
practice and assist with complex cases. While mentoring occurs for some rural practitioners informally, formal mentoring would provide systematic support and be available for evaluation.

Methods

A review of literature on mentoring was conducted by one of the authors to seek out literature on (i) definitions and models of mentoring, (ii) mentoring programs and their outcomes, (iii) barriers and enablers to successful mentoring relationships, (iv) mentoring of health professionals/students, and (v) mentoring programs conducted in rural areas. The databases of PubMed and Medline were used to select papers for review. A second literature review was conducted independently by another author who checked the first review and added other papers. The second review included GoogleScholar in addition to the databases to capture articles in non-health journals. In both searches, keywords of mentor* and mentee* were used along with one of the following (or a variation of it): medical student, coaching, role model, supervisors, formal, informal, voluntary, obligatory, adult learning, impact, outcomes, subjective outcomes, rural, remote, women and ethnic minorities. From identification of 362 papers, 39 articles reporting original research, literature reviews and citation in other works were selected based on their relevance. These 39 were reviewed to provide detail on mentoring, highlighting rural studies, issues relevant to mentoring rural health professionals as well as barriers to and enhancers of mentoring programs in rural and remote environments. This review and other rural literature was used to develop a model of rural mentoring. Before presenting our model, an overview of mentoring is provided.

Mentoring

The roots of mentoring trace back to ancient Greece where the goddess Athena (in Homer’s Odyssey) assumed the characteristics of the old man, Mentor, by acting as a guide to Telemachus in his time of need. Definitions of mentoring have since expanded, but key elements involve a relationship, an adult learning context, professional development goals, reflection and re-examination of goals. For example, Hay describes ‘a developmental alliance’, Noe identifies both career and psychological support, and Bennetts refers to mentoring as ‘intimate learning alliances that happen naturally’.

Mentoring can be formally organised and obligatory or occur informally and ‘naturally’. However, for the principles of adult learning to be maintained, mentoring should be engaged in willingly. Characteristics of ‘good’ mentors include being empathetic, good role models, available, interested and non-judgemental while mentees need to be willing to accept criticism, have the ability to set their own agenda, reassess their performance and follow through on mentor suggestions. Kram identified four phases of mentoring, including the initiation phase, the cultivation phase focusing on psychological and career support, then the separation phase followed by a re-definition phase where the relationship is re-established under a different form.

In terms of outcomes, most participants of medical mentoring programs have reported high levels of satisfaction, career success in terms of publications, funding and collaborations, and career advancement. While outcomes have focused on the mentee, Garmel identified benefits and impacts for the mentor: rekindled excitement, enthusiasm and professional satisfaction; sense of reward; exposure to new ideas and opportunities; pride in mentee success; personal growth; increased creativity; sharing values with others; and career advancement. Negative outcomes have included increased workload for mentors, the inability to choose mentors, conflict, patronising attitudes of mentors and mentors providing solutions rather than allowing the mentee to work out solutions. Jacobi highlights concerns that cross-gender and cross-ethnicity mentoring relationships may be less effective and occur less often. Overall, while there is
**TABLE 1: Models of mentoring**

<table>
<thead>
<tr>
<th>Aspect of Mentoring</th>
<th>Cloning</th>
<th>Nurturing</th>
<th>Friendship</th>
<th>Apprenticeship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>Trainer and trainee</td>
<td>Safe, supportive, reflection</td>
<td>Supportive, close relationship</td>
<td>Supportive, training</td>
</tr>
<tr>
<td>Outcome</td>
<td>Become mentee</td>
<td>Grow through support</td>
<td>Grow through support</td>
<td>Maximise opportunities</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>Maintained</td>
<td>Maintained</td>
<td>None</td>
<td>Maintained</td>
</tr>
<tr>
<td>Adult learning</td>
<td>Included</td>
<td>Variable</td>
<td>Variable</td>
<td>Included</td>
</tr>
<tr>
<td>Reflection</td>
<td>Little</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Potential problems</td>
<td>Lack of individual growth</td>
<td>Dependence</td>
<td>Unprofessional alliance</td>
<td></td>
</tr>
<tr>
<td>Suitability for rural and remote health professionals</td>
<td>Not suitable</td>
<td>New professionals to rural/remote – supportive relationship to avoid social isolation</td>
<td>Senior practitioners and academics – friendships unavoidable but support provided</td>
<td>Rural students – supported and trained in preparation for rural or remote practice</td>
</tr>
</tbody>
</table>

*While the first six aspects are derived from the literature, the last aspect (suitability for rural/remote), comes from the authors’ analysis.*

satisfaction with the process of mentoring, the long-term benefits to a mentee’s career have not been firmly established. Mentoring relationships can be classified into four models (Table 1). The cloning model grooms the mentee to produce a ‘clone’ of the mentor. While this can be a form of succession planning, it is more prescriptive and does not allow for individual goals, growth and reflection or changes in practice styles. The nurturing model creates an open, safe environment for the mentee as a process to facilitate learning. However, issues of hierarchy and dependence can be problematic. The friendship model views the mentee and mentor as equal professionally, and a reciprocal process of support follows where both parties benefit; however, there is potential for unprofessional behaviour. The apprenticeship model is more traditional where a senior professional mentors a junior colleague and the hierarchy is maintained. This model includes attributes of the previous three models.

While cloning is usually inappropriate in most contexts, the other models offer styles suitable to rural and remote settings where health professionals and patients are more likely to know each other, where interprofessional team work is more common, and where patterns of relationships can be more intense due to smaller, geographically isolated populations. The different mentoring models are likely to suit different types of rural or remote health professionals, based on individual needs and career stage. For example, rural and remote health students are likely to benefit from the apprenticeship model, health professionals new to rural/remote could benefit from the support of a nurturing relationship, and senior practitioners/academics can develop mentoring relationships with peers where friendships in rural/remote contexts are inevitable. In rural and remote settings with different patterns of interaction, more generalist practice, high workloads, closer connection with local communities and greater isolation from specialist care and professional support, mentoring may support rural and remote practitioners. A model of mentoring for rural and remote contexts is presented.

**Mentoring in rural and remote practice**

There is little literature on mentoring in rural health, and few rural mentoring programs have been well documented or evaluated. In rural Arizona, a mentoring model was used to teach nurses not from the area about cultural practice and understanding of indigenous populations. In rural Greece, Petridou described a structured mentoring program for rural women entrepreneurs using technology to communicate across geographical distance (emails, text-based and telephone communication). These technologically mediated interactions were found to improve mentoring (compared with face-to-face interactions), due to better transfer of honest feedback, development of trust and role modelling. This suggests that technology can aid mentoring in rural and remote settings where remoteness can make communication more difficult.

Formal and informal mentoring is reported anecdotally as common among rural and remote practitioners, although there is little specific literature on mentoring in rural or remote health settings. While the benefits, impacts and outcomes of non-rural/remote mentoring...
are likely to occur, there are specific aspects of rural and remote practice that encourage mentoring.

1. For reasons of retention, senior health professionals have an incentive to mentor junior professionals. Therefore, some senior practitioners may view mentoring as an obligation.

2. Having fewer health professionals in a specific region means that there are strong relationships between student/junior health professionals and their senior counterparts from which a mentoring relationship can naturally form.

3. Within rural practice, there tends to be blurred boundaries between professional and personal roles, which may be conducive to mentoring relationships that provide psychological and career support.

4. Rural/remote practice is by its nature less hierarchical and more interprofessional, suggesting that open, honest relationships are more likely to occur.

5. The use of technology within rural and remote practice makes connecting mentors and mentees in different locations possible. Petridou suggests mediated communication is particularly suited to reflective and honest mentoring relationships. Given these enablers, implementation of a formal mentoring program would acknowledge current informal mentoring.

However, rural and remote practice also creates some barriers to mentoring which need to be acknowledged.

1. The high workload of senior rural health professionals could restrict time for mentoring.

2. Given the lack of rural and remote health professionals, there is less access to rural/remote mentors and less choice of potential mentors.

3. A fee for service system, in many cases, means that mentoring time is unpaid, requiring voluntary involvement by both mentor and mentee. However, this would ensure genuine commitment to such a process.

4. Any conflicts or problems arising from the mentoring relationship could jeopardise the working/business/employment relationship, especially between the senior and junior staff working in the same practice.

5. Confidentiality in rural and remote settings (where everyone knows everyone) is more difficult to maintain. It may discourage mentees from divulging personal perspectives for fear of being ‘judged’ by a colleague they work with daily. This can be addressed through documentation of boundaries and expectations at the outset, which can be reviewed at key intervals during the mentoring process.

6. Remote health professionals are often isolated from others in the same profession making mentoring more difficult logistically and decreasing the opportunity for such relationships to occur naturally. However, some remote professionals seek out personal and career support because of their isolation. The use of communication technology to connect mentors and mentees in different remote locations may overcome this barrier.

Therefore, mentoring of health professionals in rural and remote settings highlights key aspects of the relationship, including expectations, boundaries, confidentiality, time and availability, goals and conflict resolution. The barriers identified question whether or not the most appropriate mentors are locally based (and have an understanding of the specific context), or are external and can provide a fresh and confidential perspective without the issues of boundaries. Clearly, in remote areas, non-local mentors will be needed, and this may be appropriate in some rural areas. What will be required is to match mentors and mentees from similar contexts, such as both working in remote Indigenous communities. The enablers suggest that a rural and remote mentoring program would formally support existing mentoring relationships, use technology to connect mentors and mentees in different locations, and increase support and career satisfaction of rural and remote health professionals to encourage retention.

Figure 1 presents a model of mentoring for rural and remote settings that is flexible in terms of co-location but requires similarities in terms of setting, gender and ethnicity; it relies on technology, varies the model based on who is being mentored and includes documentation of time commitment, expectations and conflict resolution at the outset. Outcomes might include a rural/remote workforce that is supported, satisfied, working towards aspirations and, therefore, more likely to stay rural.

Conclusion

In programs addressing the rural and remote health workforce, less emphasis has been given to individual level support, both professionally and personally. Mentoring rural and remote health professionals may allow them to grow, focus on personal goals and provide practitioners support during difficult times. While there are geographic barriers and time constraints, the outcomes could involve a satisfied workforce in which individuals achieve their desired career goals. Implementation of a mentoring program using the model outlined here could provide a novel way to support the rural workforce, and evaluation would provide evidence of its impact and potential to achieve a

© 2014 The Authors
Australian Journal of Rural Health © National Rural Health Alliance Inc.
more sustainable rural workforce. Given its potential, trialling of a mentoring program based on the model presented is recommended.

References

4 Humphreys JS, Jones MP, Jones J, Mara PR. Workforce retention in rural and remote Australia: determining the factors that influence length of practice. MJA 2002; 176: 472–476.